MANAGED CARE: AN INDEPTH EXAMINATION

HEARING

BEFORE THE

HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

FIRST SESSION

SEPTEMBER 26, 1993

Printed for the use of the Committee on Government Operations

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MANAGED CARE: AN INDEPTH EXAMINATION

SUNDAY, SEPTEMBER 26, 1993

HOUSE OF REPRESENTATIVES,
HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS SUBCOMMITTEE
OF THE COMMITTEE ON GOVERNMENT OPERATIONS,
Albuquerque, NM.

The subcommittee met, pursuant to notice, at 9:40 a.m., in the Albuquerque Convention Center, Albuquerque, NM, Hon. Edolphus Towns (chairman of the subcommittee) presiding.

Present: Representatives Edolphus Towns, Steven Schiff, and John L. Mica.

Also present: Brenda E. Pillors, professional staff member; Martine M. DiCroce, clerk; and Martha B. Morgan, minority professional staff, Committee on Government Operations.

OPENING STATEMENT OF CHAIRMAN TOWNS

Mr. TOWNS. The Subcommittee on Human Resources of the Government Operations Committee will come to order.

Today's hearing is on managed care. I would like to begin by saying welcome to the witnesses here. We look forward to hearing from you, because I think this is a very timely subject and I don't think that we could have timed it any better because of what is going on in the country.

Mr. SCHIFF. Appreciate the President's cooperation on that.

Mr. TOWNS. And I am grateful to the subcommittee's ranking minority member, Mr. Schiff, for inviting us here to have this hearing in this city.

Of course, managed care, as far as our health care system, is being talked about a great deal, and this is a place that has been doing it for quite some time, and I think this is probably the best place in the Nation to have a hearing of this nature.

As you know, the health care delivery system in this country is in a crisis situation. We have over 37 million people without any health insurance at all and, a lot of others who are underinsured and can no longer rely on job-related health benefits because their employers consider that copayments are too high.

Just this past week, the President announced a health reform plan which is based on a managed competition model which is dependent upon the use of managed care entities for delivery of health services.

Today's hearing is the first in a series of hearings on the President's health reform proposal. I think that we need to learn as much about this as possible. Employers and States are looking for

ways to stem the rising health care expenditures in terms of employee benefits and contributions, in the case of States, to the Medicaid program. Albuquerque is noted for its extensive hospital-based managed care market. In fact, over 75 percent of the city's insured population received health care services through a managed care plan.

Despite Albuquerque's embrace of managed care as a preferred form of health care delivery, New Mexico also has some unique problems which we will have to address in our review of the health care reform package when we look at the plan which has been put forth by the President of the United States.

Additionally, New Mexico, has the highest proportion of residents without health insurance, more than any State in the Nation. And the residents of New Mexico have the greatest difficulty gaining access to primary care and prenatal care. If we can adequately address the health problems here in New Mexico, then it may well be a blueprint for improving health care throughout the United States of America. Our ability to improve health access for all Americans may well depend on how well managed care systems can deliver health care services.

I look forward to hearing from today's witnesses about the problems as well as the successes of managed care that you have experienced here in Albuquerque.

Also, let me pause now to say a thank you to the people of this area for sending this outstanding Member to the U.S. Congress. He is one that I have enjoyed working with, and has a way of dotting every "I" and crossing every "T" and making certain that we do it and we do it right. This is a voice that you can always depend on when it comes to moving things in the right direction.

I pause now and yield to the ranking member of the subcommittee, Mr. Schiff, who is known to the people of Albuquerque, NM.

Mr. SCHIFF. Thank you, Mr. Chairman. And, first of all, thank you for those gracious remarks. I have a few things to say before we get started. I won't be very long. Mostly it is a group of thank yous, to tell you the truth.

First to you, Mr. Chairman, your staff, and colleague Congressman Mica from Florida for coming here to Albuquerque, NM, for this field hearing. I would like to explain that the Government Operations Committee, of which we constitute a subcommittee, is primarily the investigatory committee of Congress. It is primarily our responsibility to develop facts on important issues and to share those facts with our colleagues and to share those facts with the administration.

I want to commend you on the field hearing that we had in New York on the subject of Medicaid fraud and the revelations that Medicaid fraud costs tens of billions of dollars; that it is now an organized crime effort, really. It is more than an occasional false claim from either a recipient of medical care or a provider of medical care. It has become a wholesale business to cheat the government, and I think bringing that information up, I hope, helped influence the President to mention the issue of fraud in his speech to the Nation the other night.

Second, I want to explain to everybody that this hearing is at a somewhat unusual time, I know, and apologize for any inconven-

ience, for the reason that Congress is in session right now and we have votes on Monday and, therefore, if we were to have this hearing it was necessary for everyone to travel on Saturday and then be able to leave early enough today to be back by tonight for the votes tomorrow. So that is the reason for this unusual hour.

If we were going to have the hearing in Albuquerque, we did not have a choice for when to set this hearing, and, again, I apologize for any inconvenience we may have caused anyone.

I want to thank the witnesses, both about ready to testify before us in a moment and the witnesses who will testify, and to say that we reached the point that the subcommittee simply, in the few hours it has here, could not hear from more witnesses, even though we know there are many more people in this community, as well as other communities, who have something credible to say.

The chairman has allowed written testimony to be accepted and to be added to the record, and, Mr. Chairman, at this time I would like to ask unanimous consent that the record of this hearing remain open for 10 days from today to receive written testimony that has not been received. I know there are people who would like to, from organizations, would like to contribute that.

Mr. TOWNS. Without objection, so moved.

Mr. SCHIFF. Thank you, very much, Mr. Chairman.

We welcome all the testimony and I can assure you that written testimony is as much a part of the record as the spoken testimony is. And also, with respect, I would say to the witnesses who will testify, we have your written testimony and we have reviewed it so it is not necessary to read every word because it is already in the record.

Yes, there is a certain hint in that, if you get the point. However, if you wish to, it is your testimony.

Just a couple more things, Mr. Chairman.

I believe that Mr. Tony Gallegos, representing Senator Pete Domenici, our senior Senator came in. I thought I saw him a moment ago. Sorry, Tony, I didn't see you to my right there. Thank you for coming and welcome on behalf of the Senator.

I don't want to neglect this. Is there any other representative of any other congressional office?

Ms. SALCIDO. I am from Senator Jeff Bingaman's office. I am Alice Salcido, and I handle all his health issues.

Mr. SCHIFF. Alice, it is good to see you again. You are welcome to stay there or join Tony, wherever you are comfortable.

Ms. SALCIDO. This is fine, thank you.

Mr. SCHIFF. Wherever you are comfortable is fine. We appreciate your being here on behalf of Senator Bingaman.

The Senators regret that they were unable to be here personally, but I am pleased they were able to send representatives.

Finally, the subject of the hearing, managed health care. You said, Mr. Chairman, we were going to study the successes of managed health care. I want to say as neutrally as I can whether there are successes or not successes, or, I think more likely a combination of the two, is the direction that I trust this hearing will go. Albuquerque, I am informed, has five HMOs operating; is that right, Steve?

Dr. KANIG. Yes.

Mr. SCHIFF. Five HMOs, and it is expected possibly 50 percent or more of the insured population of this area is enrolled in an HMO. And from that I have been told a number of stories, frankly both positive and not positive, about HMO experiences. And since the President has made HMOs a significant part of his plan, in that, if I understand it correctly, an HMO choice must be one of the choices offered in these regional purchasing alliances, I think it is very important, with the experience we have in Albuquerque, that we examine to see what the successes have or have not been.

And I again repeat I have tried to state that as neutrally as I could. This is where we want the witnesses to come in.

With that in mind, Mr. Chairman, I again thank you for holding this hearing. Thank you for taking the time to come here, and I yield back for you to introduce the witnesses.

Mr. TOWNS. Thank you very much.

I would like at this time to yield to Congressman Mica from the great State of Florida.

Mr. MICA. Well, thank you, Mr. Chairman, and I too want to take just a moment to commend both you, Chairman Towns, and the ranking minority member, Mr. Schiff.

This community is fortunate, really, to have probably the first congressional hearing in the Nation since the President announced and shared with the Congress and the country his plans. This is a copy of his address before the joint session, which I brought along.

But I do commend you on your leadership. And you folks should know, too, that we are in the middle of some of the difficult debates. Finishing the appropriations bills have been going kind of nonstop, and they have taken time to come up here and hold this first hearing in Albuquerque, and it is important because this committee does deal with the structure of government and will look at the structure and parts of this important plan.

The whole country is looking forward to seeing some resolution of the many problems we know we have and, hopefully, we can learn by the experience that Albuquerque and New Mexico have gained, both successes and, as Mr. Schiff said, also the shortcomings.

So I am pleased to be with you and, again, with the leadership of the Congress that is here with me today. Thank you.

Mr. TOWNS. Thank you very much.

Before we go to the witnesses, I think that Congressman Schiff sort of set the tone to indicate the fact that we have your statements and they will be included in the record and we would like you to summarize.

I will start off without trying to use this clock. What we try to do is, within 5 minutes, we will have each of you summarize and then it will allow us an opportunity to raise some questions with you. I say sometimes when we have hearings in New York that there is a trap door and after 5 minutes out the trap door you disappear and we just continue the hearing.

This morning we do not have a trap door, but we hope you will try to stay within the 5 minute timeframe because I think with the question and answer period we can accomplish a lot more. So let's start with you, Mr. O'Brien.

STATEMENT OF WILLIAM O'BRIEN, REGIONAL VICE PRESIDENT, BLUE CROSS/BLUE SHIELD OF NEW MEXICO, REPRESENTING THE NEW MEXICO HMO ASSOCIATION

Mr. O'BRIEN. Good morning. Thank you very much Chairman Towns, Congressmen Schiff and Mica and subcommittee members. My name is Bill O'Brien, regional vice president of Blue Cross/Blue Shield of New Mexico. I am here representing the HMO Association of New Mexico. The current president of that association is the president of our wholly owned subsidiary HMO, HMO New Mexico, Blair Christianson, who was not able to attend and asked if I would fill in.

The comments I will make will be limited to representing the association's views and not those of Blue Cross/Blue Shield of New Mexico, where we may have some variation on some of the points that we will be making.

As we have said already, there are five HMOs in New Mexico representing about 60 percent of the insured population within the Albuquerque marketplace. There are four IPAs, independent practice affiliations, and one staff model. The current shift is moving managed care out of the Albuquerque marketplace into some rural, or what would be considered by national standards certainly rural communities. The most successful of which have been Santa Fe and Las Cruces. There are current activities going on in Farmington, Raton, New Mexico, Alamagordo, Ruidoso and other smaller towns that are really beginning to embrace some of the concepts of managed care.

I think managed care is really at the root of what HMOs are all about. It is beginning to focus on the appropriate and efficient delivery of health care services while maintaining a cautious eye on the financing budgets that everyone has established.

The growth rate nationally is increasing. The 1992 national growth rate was 7.2 percent, the largest single year growth rate in the last 4 years. Of the entire Nation 16 percent are now enrolled in HMOs. Western States have always been the leaders in HMO enrollment, typically because western employers have not paid for as much traditional indemnity coverage as the eastern employers and the rust belt employers of the Midwest, where benefits have been predominantly base plus major med plans.

The HMO movement has been much more effective in marketplaces where those 100 percent benefits were truly an incentive to drive people to the right networks of providers. In an eastern market, where everyone is already at a 100 percent benefit level, it is very difficult to create incentives to drive people into tighter networks or more selective circles of providers.

The New Mexico numbers for cost increases, the average increase from the past years have been very moderate, generally maintaining a 4 to 6 percent margin between the rate of escalation and indemnity plans. Managed care has been the basic concept behind all of that. It strategically coordinates health care delivery systems and watches activities with providers resulting in some cost savings through efficient deliveries.

Now we are beginning to get into some evolution of other care, point of service modifications to HMOs, where networks are not as limited and there are some benefits for people that move out. We

are beginning to see some hybrids with PPOs, or preferred provider organizations, creating gatekeeper concepts at the front end of their plans to parallel or look like HMOs.

So the real heart of all of managed care begins to get to provider networks. Getting the right providers, incenting them correctly, and then monitoring basically the outcomes for maintaining quality.

The key role of managed care seems to be centered on primary care physicians, and there is a critical shortage not just in New Mexico but most of the country. It is particularly felt in most of New Mexico where various communities are dramatically underserved in physician care.

Provider reimbursements are changing. Traditional fee-for-service gives very limited control over numbers of services that physicians provide. Indemnity insurance attempts to deal with that through micromanagement of how things work.

Some HMOs also do some similar very intensive physician oversight to maintain how many services are provided. We think that the associations are moving toward different levels where it is more a collaborative effort in the financing or risk sharing with the providers rather than just the insurers of the financier. Some of those vehicles are risk pools, capitation amounts, and diagnosis-related groupings or per diem global rates for possible services.

Maintaining quality has been one of the main goals of all the HMOs active in the Albuquerque marketplace and as they move out into the rural areas for expansion; credentialing and profiling the providers to make sure they are getting the right providers into the distribution of services. The goal is obviously to lower costs and then maintain the escalation to be somewhat more tolerable than certainly we have seen in unmanaged fee-for-service insurance.

The national cost of HMO plans in 1992 was 8.8 percent versus almost 15 percent for traditional indemnity insurance. HMO and indemnity types of comparisons are very difficult because of the benefit differentials. HMOs tend to provide care for preventive, immunization, well baby checkup, general physicals and more frequency on the early end of the delivery of health care. Their prime reason is to establish relationships with physicians, so that people who know and trust their physician will get early care rather than delaying something until it is much more costly.

One of the prime satisfiers has been customer research, where we have gone out and asked the employers and their covered employees how they are happy and what areas of satisfaction they have been developing. A recent survey, in March 1993, showed 81 percent of all employer respondents, that would be the employers themselves, more importantly their employees that were covered under HMO options, said they favor purchasing their insurance through HMOs. They feel it maintains good quality and that they could get better and more stable costs.

Generally, national surveys run by all HMOs and by some independent surveying vehicles have shown that 9 out of 10 members are satisfied overall with the access and quality of care practiced in HMOs.

The overall hope is to reduce the escalation in medical trends. That basically takes on a strategy of managing utilization through

reduced hospital payments, admissions, inpatient days without reducing quality of care. I don't think any HMO in this country wants to withhold care for any covered employee at the expense of creating a quality outcome.

We applaud Congressman Towns and Congressman Schiff for placing health care reform at the top of their agenda. The New Mexico HMO Association wants to work with the administration and Congress on practical solutions that can be enacted in 1994 and 1995.

The unique urban and rural environment of our State has always been a challenge with regard to access and choice of health care services. The resulting experience of this challenge provides a sound platform for discussion of the roles of HMOs and managed care in the solution of health care reform.

And I thank you very much for the opportunity to address you.

Mr. TOWNS. Thank you very much, Mr. O'Brien.

[The prepared statement of Mr. O'Brien follows:]

HEARING BEFORE THE HOUSE COMMITTEE

ON

GOVERNMENT OPERATIONS

SUBCOMMITTEE ON HUMAN RESOURCES

AND

INTERGOVERNMENTAL RELATIONS

MANAGED CARE: AN INDEPTH EXAMINATION OF HEALTH MAINTENANCE ORGANIZATIONS

WRITTEN TESTIMONY PREPARED BY:

The New Mexico HMO Association

THE NEW MEXICO MARKETPLACE: HMO PENETRATION

The greater Albuquerque's and Santa Fe's population of 800,000 is one of the most concentrated managed care markets in the nation. Approximately sixty percent of the insured population is enrolled in one of five HMOs; four IPA and one staff model design. According to the Group Health Association of America, Inc., June 1993 Patterns in HMO Enrollment, 20 percent of the insured population were enrolled in HMO's in New Mexico at the end of 1992.

The market dominance of HMOs in the Albuquerque/Santa Fe area is a fairly recent development. Four of the five HMOs have been operational for less than 8 years and the oldest HMO, Lovelace, Inc., has only been in existence for 20 years.

With Albuquerque/Santa Fe markets fairly saturated with HMOs, some HMOs and other managed care organizations have turned their attention to rural New Mexico. Rural communities, such as Espanola, Las Vegas, Las Cruces, Alamagordo, and Soccoro, are now benefiting for the managed care programs. New Mexico is unique in the sense that it has been able to demonstrate that managed care can be successful in rural communities.

HMO ENROLLMENT: A STRONG RECORD OF GROWTH

In 1992 total national HMO membership grew by 2.8 million people for a growth rate of 7.2 percent. This is the largest increase in four years, signifying that 16.1 percent of the nation's population is now enrolled in HMO's. The largest enrollment increases nationally were in network and independent practice association model HMO's, with median increases of 9.7 percent and 8.1 percent respectively.

Western states in particular continue to have the highest HMO penetration. As of July 1, 1992, the Western region of the United States had approximately 25 percent of the population enrolled in HMO's.

Consistent with these national growth trends in HMOs, HMO enrollment in New Mexico has increased steadily for the past four years. In 1992, HMO enrollment in New Mexico totaled 241,873, or an increased 6.6 percent from 1991. This net growth rate is also consistent with the prior years in New Mexico. During the period of 1988 to 1992, HMO enrollment increased on the average 7.5 percent per year.

MANAGED CARE: AN EVOLVING CONCEPT

HMOs use managed care as the basic philosophy behind their entire existence. Managed care is a structured health care financing and delivery system that provides cost effective health care through organized relationships with physicians, hospitals, and other health care providers. Managed care strategically coordinates health care delivery systems and conducts rigorous medical management activities with physicians and hospitals. The end result: managed care programs deliver cost savings over traditional insurance programs and consistently high quality medical care.

Managed care has changed a great deal in the last 10 years in New Mexico. In the early 1980s, managed care was regarded as only preadmission, prospective and concurrent utilization review activities tacked onto a traditional insurance program. Now managed care is establishing a new tradition as it evolves into a sophisticated form of provider network management proven to reduce medical expense trends.

Today, managed care is truly a mainstream concept. Employers and consumers have gained experience and have begun to experiment with the new managed care products, such as Point of Service (POS) programs. POS programs allow employers to combine the best features of an HMO and Preferred Provider Organization (PPO) network. If a POS member wants to receive the HMO-style benefits with minimal copayments, they coordinate all of their care through a primary care physician. But if an occasion arises when a POS member wants to self refer or see a non-network provider, they can do so at a lower benefit level. The POS program gives members the best of both worlds: predictable, low out-of-pocket costs through an HMO network and maximum flexibility to choose when and where your health care needs are met.

PROVIDER NETWORKS: THE HEART OF MANAGED CARE

Without a strong network of physicians, hospitals, and other health care providers, an HMO cannot function successfully. That's why successful managed care programs devote considerable time, effort, and expense to develop and manage provider networks. Building the network is only the first step. There are many succeeding steps involved in maintaining a network. These activities include monitoring and analysis of practice patterns for volume, type, cost, and manner in which physicians and hospitals deliver services.

A managed care organization considers a number of factors when developing a provider network. The network must include enough providers to ensure access and choice for members, but it also must be limited to a manageable number of high-quality, cost-effective providers. A critical consideration for network inclusion is a provider's ability to consistently meet the managed cares program requirements.

PRIMARY CARE PHYSICIANS (PCPs): A MEMBER'S PERSONAL PHYSICIAN

When a member enrolls in an HMO, the first and most important decision a member makes is the selection of a PCP.

The role of the PCP is to manage all of the members medical needs. The PCP serves as a gatekeeper, controlling access to specialists and hospital services. The PCP concept is designed to prevent HMO members from seeking care directly from high-cost specialists when equally effective treatment is available from plan providers at lower cost. In an HMO, the PCP concept is the most critical component in delivering cost-effective medical care.

There are many advantages to selecting and receiving care from a PCP. The PCP coordinates all routine and specialty care and maintains a complete medical history on each member. Records are centrally located, allowing the PCP to easily coordinate the members medical care needs. This helps ensure that members receive the best and most appropriate health care services possible.

PROVIDER REIMBURSEMENT: A WAY TO CONTROL COSTS

Most traditional insurance plans pay providers on a fee-for-service basis, making payment for each individual service after it has been delivered. The problem with this method of payment is that it provides limited control over the number of services they can provide. This lack of control fuels health care cost inflation.

Provider payments in HMOs are designed to encourage appropriate levels of service and limit cost increases. This is accomplished with reimbursement programs which change the incentives for providers about the delivery of health care services. In an HMO environment, financial risk is shared between the HMO and its contract providers through methods such as capitation, per diem, and risk pools. One of the innovative hospital payment methods frequently used is Diagnosis Related Groups (DRG), a system that sets payment rates in advance based on the medical diagnosis. This payment methodology adequately reimburses the hospital for their services yet aligns incentives to get the patient out of the hospital as soon as possible.

Provider payment methods will continue to evolve as managed care programs grow and mature. The objectives will continue to be maintaining high quality care, ensuring long-term savings, sharing appropriate levels of risk with providers and rewarding those providers who can manage the delivery of services in a cost-effective manner.

CREDENTIALLING AND PROFILING: A WAY TO DEMONSTRATE QUALITY

Over time, managed care plans have become very sophisticated in their ability to assess and monitor not only the cost, but the quality of care provided through provider networks. Credentialling programs have become a primary vehicle for the screening and selection of providers for network participation.

Monitoring the performance of physicians and hospitals in the network is another crucial aspect of a managed care program. The plan must ensure the compliance of network providers with the administrative and contractual requirements of the managed care program. Provider profiling is a management technique based upon data reports of key cost, utilization, and quality indicators. It offers a snapshot of an individual provider's pattern of health care delivery. The information is used to analyze and compare the performance norms established by the practices of similar types of providers.

LOWER COSTS: A BENEFIT TO HMO MEMBERS

While premium for traditional insurance coverage used to be slightly less than, or about the same as those charged by HMOs, several recent studies have shown that HMO premiums now average 20 percent less than premiums for traditional indemnity coverage. When out-of-pocket costs (coinsurance) are taken into consideration, the difference becomes even more apparent, with HMOs emerging as clearly more cost-effective at delivering care. To illustrate, in 1992 the national cost of HMO plans increased by 8.8 percent, while traditional indemnity plans rose 14.2 percent.

HMO BENEFITS: AN EMPHASIS ON PREVENTION

The very name of an HMO implies health maintenance and prevention. HMO benefits have long been structured to encourage members to receive preventive care before a problem becomes a major illness. In an HMO setting, pre-natal care, immunizations, well-baby checkups, general physicals, and routine diagnostic testing are covered services. Preventive care has proven effective at limiting health care costs with early detection of developing medical conditions.

CUSTOMER SATISFACTION: THE BOTTOM LINE

The bottom line is that consumers who try HMOs and managed care, like it. According to the Blue Cross and Blue Shield Plan Managed Care Membership Survey, conducted by The Gallup Organization in 1991, nine out of 10 members were satisfied with the quality of medical care in Plan HMOs. At least 88 percent indicated overall satisfaction with their managed care program.

The membership survey is conducted every year to develop objective, statistically valid results that highlight areas where performance is strong and where it can be improved. The survey covers:

- quality of care provided by members;
- ease of access to network providers;
- quality of network physicians and hospitals;
- efficiency of administrative services; and
- overall program performance.

In every area concerning quality of care, more than 90 percent of Blue Cross and Blue Shield Plan HMO members indicated satisfaction with the care they receive. The majority of members were satisfied both with the professional expertise and care received from their primary care physicians. They were also satisfied with the care and personal interest extended by other physicians and their staffs.

MANAGED CARE: IMPACT ON HEALTH CARE EXPENDITURES

Managed care utilization management activities have saved members billions of dollars over the past decade. This has resulted in a substantial reduction in medical expense trend and a powerful endorsement for managed care. A comprehensive study concluded that utilization management strategies of Blue Cross and Blue Shield Plans significantly reduced the amount paid for members' hospitalizations. The study, (Scheffler, et al., "The Impact of the Blue Cross and Blue Shield Plan Utilization Management Programs, 1980 - 1988," Inquiry, Fall 1991) examined the impact of utilization management programs on hospital payments, admissions, and days. The findings showed that:

- In 1988, admissions for Blue Cross and Blue Shield Plan enrollees were reduced by 19.8 percent, compared to what the rate would have been without utilization management programs in place.

- In 1988, inpatient days for Blue Cross and Blue Shield Plan members were 24.2 percent lower than they would have been and payments were reduced by 24.5 percent.

- Taken together, Plans using preadmission certification, concurrent review, and other utilization management programs had inpatient payments approximately $2.6 billion lower than Plans without such programs over the nine-year study period.

While these results indicate that utilization management, in general, is effective, provider network-based programs such as HMOs are even more effective in reducing inappropriate utilization. Based upon data reported by Blue Cross and Blue Shield Plan utilization reports, inpatient utilization statistics show that Plan HMOs, most of which are IPA models, have 31 percent fewer inpatient days per 1000 members than non-network products.

Furthermore, savings from managed care are not simply a one-time phenomena. Comparing the rate of medical expense trends from 1987 to 1991 clearly illustrates the ability of managed care to slow medical expense increases over time. During this time, medical expenses increased an average of 56.5 percent for Plan traditional products, while the rate of increase of Plan HMOs was 36.6 percent. Plan HMOs held the annual rate of medical expense growth to just 9.2 percent.

SUMMARY

Managed Care is the center piece of health care reform, and it is clear that given New Mexico's demographics and HMO penetration, that reform will work in our state. The fundamental goals of health care reform are access for all New Mexicans to the health care system, increased efficiency in the delivery of care, and control of health care costs.

We applaud Congressman Schiff for taking health care reform to the top of his agenda. We look forward to working with Congressman Schiff in the months ahead and we will make ourselves available for any assistance we can provide to help move reform forward.

Mr. TOWNS. Dr. Kanig; is that correct?
Dr. KANIG. Kanig.
Mr. TOWNS. Dr. Kanig.

STATEMENT OF STEVEN P. KANIG, M.D., PRESIDENT ELECT, GREATER ALBUQUERQUE MEDICAL ASSOCIATION

Dr. KANIG. Good morning, Chairman Towns, Representative Schiff, subcommittee members. My name is Dr. Steven Kanig, and I am president elect of the Greater Albuquerque Medical Association. I practice as a nephrologist at the Lovelace Health Systems and my opinions are strictly my own. I very much appreciate the subcommittee's invitation to share some thoughts on the topic of managed care and HMOs.

As the chairman noted, Albuquerque has one of the highest penetrations of prepaid care in the United States and the emergence of large health care delivery organizations here anticipates what will likely happen nationally.

Managing care to ensure high quality and control cost is the avowed mission of these organizations. Each is pursuing a strategy that is aimed at maximizing its competitive position. There are significant potential advantages to the power and economies of scale that organizations can bring to bear in solving problems of access and inefficient use of resources, but it is very important to critically examine the tools of managed care to anticipate how patients will actually be affected.

Measurement of outcomes is designed to demonstrate effectiveness and quality of care, but appropriation of this tool for marketing purposes may greatly diminish its value while increasing administrative costs. Instead of promoting genuine research efforts aimed at demonstrating clinical effectiveness, we may see junk science aimed at gaining market share. Integrated information systems, such as electronic medical records, will greatly contribute to increased efficiency and improved quality and will be greatly welcomed by physicians.

Continuous quality improvement in customer orientation are worthwhile goals. Attempts at true improvement in health care delivery and adherence to the highest medical standards can only be applauded, but many physicians are concerned that the notion of quality has become just another marketing concept and has nothing to do with true quality of care. And who are our customers? To an organization, customers usually mean large employers; while to physicians customers mean individual patients.

Employers have economic concerns which may well come into conflict with the health care needs of individual employees. Health care organizations see growth as necessary for economic survival, but the imperative to grow has bred enormous duplication of resources and has hindered the potential for cooperative efforts.

For example, in the area of community health proposals. Locally, Healthnet New Mexico died for lack of financial support from health care organizations which instead saw advantage in marketing their own efforts at health promotion.

Cost containment is accepted as necessary and is the primary raison d'etre of managed care, but institutional efforts at cost containment may come into conflict with physicians' obligations to our

patients. For example, physicians are occasionally put in the very uncomfortable position of acting as advocates for our individual patients in disputes over health care coverage with the very organizations with whom we have entered alliances.

An even more worrisome concern is the system of capitation and restrictive gatekeeping. Under capitation, physicians are paid preset amounts for care of a defined population of patients. Restrictive gatekeeping is a system in which either the physician's income or the money available to the physician to provide care for other patients is tied to the physician's proficiency in limiting tests, treatments, and consultations. Restrictive gatekeeping implicitly makes bedside rationing the modus operandi of cost containment.

Individual physicians or groups of physicians will have to decide who will not get certain kinds of care. Restrictive gatekeeping turns the conception of a congruence of interest between parents and physicians on its head, and puts the physician into the role of adversary rather than advocate. How can trust be maintained when a patient must feel wary that a physician may withhold care or avoid a specialty referral for personal financial considerations?

We must recognize that the physician-patient relationship is the bedrock of effective medical care and we should not create a system that destroys the trust that cements that relationship, and rather, rationing decisions should be made by society after open debate and with full accountability.

There are numerous cost management strategies that should be strongly considered. The principles of decision analysis and cost effectiveness should be an integral part of medical education. Effective tort reform is absolutely essential to remove the impetus for defensive medicine.

Critical and unbiased technology assessment should be done on a national level and include scientifically conducted studies of effectiveness and outcomes. This type of assessment can form the basis for rational and humane rationing decisions made by society at large. Good research should also be the basis for practice guidelines, which cannot and should not attempt to delineate all care.

Society will have to come to grips with the problem of futile care and care for those at the extremes of life.

Efforts at health promotion, disease prevention and patient education will decrease some of the long-term costs of care. Incentives that reward unnecessary care should be removed without substituting disincentives for appropriate care. Various means might be employed, including salary arrangements and more effective identification and education of outliers.

Allowing physicians to see where they stand in relation to their peers is a powerful tool. Dissemination of actual cost data would be a welcome tool not heretofore available to most physicians. Physicians want to practice cost effectively if given the information to do so.

Case management and using teams of primary and specialist providers working together will increase efficiency and quality. It should not be assumed that primary gatekeepers automatically provide the most cost-effective care. And the expense of some of the health care parasite industries must be brought under control.

The underlying theme in all these suggestions is knowledge and education. Micromanagement of the physician-patient relationship, with reviewers second-guessing all patient care decisions, is highly intrusive, disruptive, expensive, and ineffective.

In my written statement, I have developed a discussion of these points in much more detail, and I would be happy to answer any questions. Thank you very much, once again, for your time and for the opportunity to address you this morning.

Mr. TOWNS. Thank you, very much, Doctor.

[The prepared statement of Dr. Kanig follows:]

House Committee on Government Operations,
Subcommittee on Human Resources and Intergovernmental Relations.
Steven P. Kanig, M.D. September 26, 1993

SUMMARY

Albuquerque has one of the highest penetrations of prepaid care in the U.S., and the emergence of large health care delivery organizations here anticipates what will likely happen nationally. "Managing care" to ensure high quality and controlled cost is the avowed mission of these organizations, but it is very important to critically examine the tools of managed care to anticipate how patient care will actually be affected.

Outcomes measurement uses clinical data and level of patient functioning to demonstrate effectiveness of care. Appropriation of this tool for marketing purposes may greatly diminish its value while increasing administrative costs.

Integrated information systems, such as electronic medical records, will greatly contribute to increased efficiency and improved quality of care.

Continuous Quality Improvement and customer orientation are worthwhile goals, but can be misused. CQI is much less effective when it is primarily employed for marketing. To an organization, customers usually mean large employers, while to physicians, customers mean individual patients. These customer sets may have conflicting priorities.

Growth has been seen as necessary for economic survival, but has bred enormous duplication of resources, and has hindered the potential for cooperative efforts, for example in the area of community health promotion.

Cost containment is accepted as necessary, and is the primary raison d'etre of managed care. Institutional efforts at cost containment may come into conflict with physicians' obligations to act as patient advocates.

Capitation and restrictive gatekeeping may include disincentives for appropriate care, which creates a system of bedside rationing. Rationing decisions should be made by society after open debate. Physicians should not be made into patient adversaries by being put into the position where they stand to personally benefit by denying appropriate care to their patients.

"Primary gatekeepers" do not automatically provide the most cost effective care.

Cost management strategies that should be considered include:

- Educating providers about decision analysis and the principles of cost effectiveness.
- Effective tort reform, which is absolutely essential to remove the impetus for defensive medicine.
- Critical and unbiased technology assessment done on a national level, including

scientifically conducted studies of effectiveness and outcomes.

- Practice guidelines, which can not and should not attempt to delineate all care.
- Dealing with the problem of futile care, and care for those at the extremes of life.
- Health promotion, disease prevention and patient education.
- Removal of Incentives that reward unnecessary care without substituting disincentives for appropriate care.
- Dissemination of actual cost data.
- Case management and the team approach to patient care.
- Control over the various health care "parasite" industries.
- Avoidance of micromanagement of the physician patient relationship.

Mr. Chairman, Committee members:

My name is Dr. Steven Kanig, and I am the President-elect of the Greater Albuquerque Medical Association. I have been in practice in Albuquerque for seventeen and a half years, initially at the University of New Mexico where I completed my training, and for the past eleven years at Lovelace Medical Center (now Lovelace Health Systems) where I practice as a nephrologist. Although nephrology is a specialty concerning kidney diseases, I do a great deal of primary care for my patients. I have had the opportunity of working as part of an organization which has helped to pioneer the development of HMO's and managed care in New Mexico, and I have maintained close relationships with colleagues in private practice. I therefore believe that I have a reasonably broad perspective encompassing primary and specialty care, and different models of practice.

I very much appreciate the opportunity to share some thoughts on the topic of Managed Care and HMO's. As a practicing physician, I have chosen to focus my remarks on how managed care may affect the ability of physicians to provide high quality, cost-effective care to our patients.

Those of us in practice in Albuquerque have been part of a rapidly evolving health care delivery system that in many ways anticipates the likely direction of federally mandated changes to come. Most all local physicians and other providers either have joined or are actively engaged in joining alliances, networks and employment arrangements involving large health care organizations. We have one of the highest penetrations of prepaid care in the United States.

In their association with these organizations, many practicing physicians have already had occasion to feel the tug of conflicting forces. While these forces may create a constructive dynamic for needed change, physicians have recognized that it will take vigilance to make

sure that our priorities remain in order.

Organizational Strategies. In Albuquerque, there are four predominant health care delivery systems: (in alphabetical order): FHP-St. Joseph-Med-Net, Lovelace, Presbyterian Network, and the University-VA-Federal systems. All will likely seek to become Accredited Health Plans under Managed Competition. It can be reasonably assumed that each system is pursuing a strategy that is aimed at maximizing its competitive position. That strategy includes certain key elements common to all: (1) Development of tools to measure and demonstrate effectiveness and quality of care, eg. outcomes measurements, (2) Integrated information systems (3) Customer orientation / Quality improvement, (4) Growth and statewide network development, and last but perhaps most important (5) Cost management.

It is appropriate to ask whether physicians should be concerned that these organizational goals might conflict with ethical and professional priorities. Certainly, there are significant potential advantages to the power and economies of scale that organizations can bring to bear in solving problems of access and inefficient use of resources. Just as clearly, organizations by their nature subordinate the needs of individuals (physicians and patients) to the overall benefit of the organization. Organizational goals should be examined against physicians' professional goals, foremost of which is to be able to provide the best possible care to as many as possible of the patients who might benefit from our skills and training.

Outcomes Measurements. In theory, this tool will provide a way to look at whether medical interventions improve the overall health and well being of our patients. Ideally, this is a great idea. Far too much of what we do has never been adequately validated by scientific study. But there are some concerns. As opposed to multicenter scientific trials, it is already apparent that outcomes measurement has been often appropriated as a marketing tool. Bias is often brushed aside as an arcane concern. Outcomes have the luster of "data," complete with statistical analysis. Gathering this data is time-consuming and increases administrative costs. There should be an obligation to use an understanding of science to ensure that these measurements are actually telling us something valid. A considerable degree of healthy skepticism should be exercised when outcomes studies are done in the service of health care organizations. "Junk science" is often worse than no science at all.

Integrated Information Systems. This is one area where organizational structure and financing can enhance professional goals, improve patient care, and decrease costs. Our present information non-systems breed inefficiency, duplication, enormous wastes of time, frustration, etc. For many, there will be some adjustments to be made, but most physicians will welcome the advent of electronic medical records with open arms. There are no basic

conflicts here, but extreme care must be exercised to build assurances of patient privacy into the coming systems.

Customer orientation / Quality improvement. These have become the buzzwords of nearly all American industry, not just health care. "Qualityspeak" has become Mom and Apple Pie. It is axiomatic that business success depends heavily on perceptions of customer responsiveness. Attempts at true improvement in health care delivery and adherence to the highest medical standards can only be applauded. The essential question, as I see it, is to what extent has the notion of quality become just another marketing concept, and how does this interfere with the true assessment of what we are doing in the name of health care? One only has to look at the marketing efforts of all of our health care organizations to see that each portrays itself as the ultimate Quality Organization. (While we all might be equally excellent, how can each be better than the others? Can Tide, Bold and Cheer all make clothes whitest?)

There is a more insidious concern. Our organizations are easily drawn into the mode of "asking our customers what they want." This begs the question of who, exactly, are the customers of health care? From an organizational perspective, customers are generally large employers who control huge chunks of business. To the extent that employers are truly benevolent guardians of their employees best interests, there is no conflict. When this superimposition of best interests generates health promotion and preventative medicine programs, and guarantees excellent, comprehensive health care coverage, everyone's goals are served. And large health care organizations have the capability to pursue population based approaches beyond the reach of individual physicians. However, employers also have their own economic concerns, which may well come into conflict with the health care needs of individual employees. (An excellent example is the rumor that one of the big three Detroit auto manufacturers was going to remove the cigarette vending machines from its plants until it allegedly recognized the negative impact of employee longevity on its pension costs.) Rather, it is the individual patient who is likely to be recognized by the physician as the true customer of health care. When we deal with matters of customer orientation and quality improvement, we should keep individual patients in mind.

Growth. Another axiom of American business is that the organization that doesn't keep growing will wither and die. I believe that this concept, as applied to health care organizations, should be examined most critically. In the name of growth, we have witnessed a free-for-all grab for market share (nationally, not just here in New Mexico) over the past decade that has had a great deal to do with the uncontrolled upward spiral in health care costs. The duplication of resources needed for each organization to provide as many services as possible has been enormous. It is apparent that as long as *any*

players pursue continued growth, all will be obligated to do the same. It is equally obvious that not all health care organizations are going to be able to grow indefinitely; there will either be a precarious stalemate, or there will be winners and losers. Keeping in mind the above discussion of quality, it is not intuitively obvious that the winners in this process will be the highest quality organizations. In the meantime, enormous quantities of talent and resources are expended in each organization's efforts to grow. This is not in anyone's best interests.

We are now starting to see in Albuquerque tiny hints of recognition that cooperative efforts make sense. Unfortunately, these efforts remain very much the exception. A great many dollars are spent annually in Albuquerque marketing all of our health care organizations (each of which is the best).

Health Promotion. Instead, what if marketing efforts were to be redirected to health promotion? Healthnet New Mexico died for lack of financial support from the health care delivery organizations, which instead saw marketing advantage in pursuing individual efforts at health promotion. It would seem to make more sense to make health promotion a community wide, cooperative effort. Since my organization's patients may be another organization's patients in five years, and vice versa, wouldn't we all benefit together if we promote health as a community? The ability to facilitate cooperative efforts at community-wide health promotion would be a feature of health system reform greatly welcomed by physicians.

Cost Containment. Clearly, our economy cannot sustain continued rise in medical costs at 3 or 4 times the rate of inflation. The driving forces behind medical inflation are not always obvious. It has been argued that physicians wield enormous power over medical costs by our ordering practices. Without disputing that fact, it should be immediately countered that physicians have seldom been given the tools to make the most cost effective decisions. We almost never have ready access to accurate cost information. And we have little if any influence over the numerous secondary industries that do not provide direct health care services, but all add cost, eg. business and marketing, insurance administration, case-by-case review, patient transportation, legions of lawyers and consultants, and many more.

Physicians are already occasionally put in the very uncomfortable position of acting as advocates for our individual patients in disputes over health care coverage with the very organizations with whom we have entered alliances. This creates a conflict of interest that very much works against the professional goal of providing the best possible patient care in a supportive environment. Fortunately, this situation does not happen frequently, but may become more common as our health care organizations become increasingly intertwined

with insurance interests. In fact, there should be great concern that this type of conflict will become more deeply ingrained in our health care system, as it appears that the insurance companies hope to own and operate a large percentage of the health care industry.

Capitation and Restrictive Gatekeeping. Capitation is a tool often mentioned as a cornerstone of cost containment. Under capitation, physicians are paid pre-set amounts for care of a defined population of patients. Various financial incentives can be used to reward care that is given less expensively. Restrictive gatekeeping is a system in which either the physician's income or the money available to the physician to provide care for other patients is tied to the physician's proficiency in limiting tests, treatments, and consultations ordered for patients.

There is great concern by physicians about the potential negative consequences of capitation and restrictive gatekeeping. Promoters of the concept suggest that the incentive for potentially unnecessary care inherent in the fee-for-service model is no less morally objectionable than an incentive to withhold care. It has been said that physician professionalism will prevent underutilization and will keep the physician-patient relationship from being undermined by patient distrust.

This assessment begs several questions: (1) Is the potential for actual harm to patients by overutilization and underutilization the same? (2) Is restrictive gatekeeping as a cost-containment tool a form of rationing, and if so, is this type of rationing appropriate? (3) If physician professionalism is potent enough to protect against abuses of underutilization, and if this professionalism will dictate the most responsible and appropriate care, why is restrictive gatekeeping necessary to begin with? And (4) Are there better strategies to achieve cost containment?

Harm to Patients. It is very difficult if not impossible to quantify harm caused by unnecessary care versus care that is withheld. Clearly, real harm can be the result of both. There is no doubt that significant treatment variability exists regionally and amongst individual physicians, with the strong implication that some care is unnecessary, and that harm related to that care may result. Examples include pain and loss of function related to unnecessary procedures and surgery, prescription of unneeded medications, and any complications that might occur. When incentives are reversed toward not providing care or consultation, injury is much more difficult to see and measure, but may be no less real. Some examples are delay in diagnosis of treatable illness and prescription of less effective medications or treatment modalities.

There is a much more insidious kind of harm that may result from restrictive gatekeeping, and that is the disruption of trust between patient and physician. One of the most vital

aspects of the physician-patient relationship is the implicit assumption that physicians act first and foremost as advocates for their patients' needs. I would venture to say that the overwhelming majority of patients would much rather have a physician who would err on the side of caution and thoroughness, rather than limit care based solely on economic considerations. Restrictive gatekeeping turns the perception of a congruence of interest between patients and physicians on its head, and puts the physician into the role of adversary rather than advocate. How can trust be maintained when a patient must constantly feel wary that a physician may withhold care or avoid a specialty referral for personal financial considerations?

The integrity of the physician-patient relationship is essential for the kind of therapeutic effectiveness we seek to maintain. Often, it is the strength of this relationship which as much as anything else, carries patients through medical crises. Studies do show that while the public regard for the medical profession as a whole has fallen, most people still do trust and respect their individual physicians. This trust should not be placed at risk lightly.

Is This Rationing? If the goal of managed care is to control costs without limiting *indicated* care, then restrictive gatekeeping is not rationing. But there is only so much fat that can be trimmed. Therefore, rationing will be necessary, but by whom? Restrictive gatekeeping implicitly makes bedside rationing the modus operandi of cost containment. Individual physicians, or groups of physicians, will have to decide who will not get certain kinds of care. This process contrasts with the effort made by Oregon to explicitly adopt a rationing policy after open public discussion and debate. Those making rationing decisions should be clearly identified and publicly accountable. Is it morally acceptable to unload this responsibility on physicians who will stand to benefit economically via their cost control successes?

Will Professionalism Protect Against Abuse? Much of the practice variability referred to earlier is clearly driven by economic considerations, usually relating to relative supply of various specialists and almost always in the setting of traditional fee-for-service reimbursement. While physicians are often noble and motivated by altruistic impulses, physicians are also human beings with economic concerns that are no different than any other group. If physicians respond in self-serving ways to the incentives of fee-for-service, why should it be assumed that they will behave any differently when incentives are reversed? Restrictive gatekeeping quite directly takes advantage of this very recognition of physicians as economic beings to provide the mechanism for cost containment.

It is therefore almost illogical to argue in the same breath that we can rely on professionalism to prevail. Of course, most physicians will behave ethically and in the best interests of their patients when the choice of treatment is clearly dictated. But we all

recognize that we live in a gray world, and are faced with dozens of situations every day when choices are ambiguous. If treatment A is effective 80% of the time but costs twice as much as treatment B which is only effective 70% of the time, which is the "right" choice? If the medical problem at hand is relatively trivial, most of us would take the small increased risk of treatment failure and go with treatment B, but what if the consequence of treatment failure might be death or major morbidity? In this setting, the decision to use treatment B is a kind of rationing, with the implication that the increased risk of a bad outcome is acceptable because it frees up money which could be used elsewhere. This kind of decision is hard enough for the best professional to make. What if we then throw into the mix the provision that the physician making the decision will get a salary bonus based on his treatment cost profile? Will professionalism guarantee the "right" decision here?

The question is not whether physicians are ethical and professional, but whether we want to allow physicians to be put into the position of having to continually balance self-interests against what is best for our patients. It should be argued that this is not morally equivalent to fee-for-service, where in most cases what is best for the physician is also best for the patient. This is not to extol fee-for-service as the best model, but simply to argue that the occasional excesses of fee-for-service do not constitute an ethical justification for restrictive gatekeeping.

Cost Management Strategies. It is worth examining a few of the assumptions that underlie restrictive gatekeeping. A major postulate seems to be that care given by the more generally trained individual will be the most cost effective. The logical extension of this postulate is that most medical conditions should be cared for not by physicians, but by "physician extenders" or nurses working from practice guidelines. (There are those who make this very suggestion.) Much of the supporting evidence derives from the studies of practice variability mentioned earlier. But a review of the literature comes up with virtually no data supporting this postulate in settings where incentives for unnecessary care have been removed. In fact, it can be very effectively argued that many problems not routinely encountered in a primary care practice can be worked up much more cost effectively by specialists who are sufficiently experienced to be confident about what *not* to order, without compromising care. I am not in any way implying that the effort to train and better compensate primary care physicians is misplaced. Quite the contrary. We should evolve systems that most effectively utilize the training of generalists and specialists working synergistically, and not simplistically assume that we can always save money by redirecting all care to "primary gatekeepers."

Another assumption is that quality of care will be ensured by good utilization review. While this may be effective in sorting out the most egregious offenders, it is fair to ask why utilization review will be any more effective in preventing underuse than it was in preventing

overuse. Furthermore, utilization review is inherently cost oriented, and quality is extremely difficult to measure. Can we be assured that compromises in quality will always be recognized and not rationalized away?

There are numerous cost management strategies that should be strongly considered. The principles of decision analysis and cost effectiveness should be an integral part of medical education. Effective tort reform is absolutely essential to remove the impetus for defensive medicine. Critical and unbiased technology assessment should be done on a national level, and include scientifically conducted studies of effectiveness and outcomes. This type of assessment can form the basis for rational and humane rationing decisions, which should follow open and vigorous debate by all elements of society, and not be left up to physicians at the bedside. Good research should also be the basis for practice guidelines, which can not and should not attempt to delineate all care. Society will have to come to grips with the problem of futile care, and care for those at the extremes of life. Efforts at health promotion, disease prevention and patient education will decrease some of the long-term costs of care. But it should be recognized that the overall economic value of health promotion efforts may show up on a different balance sheet as increased productivity of a healthier work force, and we should not count on health promotion to produce bottom line savings in the health care budget.

Incentives that reward unnecessary care should be removed without substituting disincentives for appropriate care. Various means might be employed to achieve this last goal, including salary arrangements and more effective identification and education of "outliers". Allowing physicians to see where they stand in relation to their peers in terms of cost effectiveness often will result in a change in behavior without any punitive measures being undertaken. Health care organizations may make very positive contributions by dissemination of actual cost data, as numerous studies have shown that physicians respond very positively to real data and constructive educational efforts. Case management is an evolving trend, and has received positive early reviews from physicians who benefit from relief from the chores of orchestrating the innumerable details of patient care. And it can only be hoped that health care organizations might exercise their considerable clout in mitigating the expense of some of the health care parasite industries.

The underlying theme in all these suggestions is knowledge and education. Micromanagement of the physician-patient relationship (with reviewers second-guessing all patient care decisions), is highly intrusive, disputive, expensive and ineffective. And any system that pits physicians against their patients should be rejected.

Thank you very much for your time and consideration.
Steven P. Kanig, M.D.

Mr. TOWNS. Dr. Merovka.

STATEMENT OF CAROL MEROVKA, M.D., PAST PRESIDENT, GREATER ALBUQUERQUE MEDICAL ASSOCIATION

Dr. MEROVKA. Close. Dr. Merovka. It is a hard name to pronounce.

I also would like to thank you very much for inviting me to participate in your hearing this morning. When I was first invited, I had a great deal of trepidation, and that is putting it mildly, because I really felt who am I to speak to a committee from the Congress? But the more I thought about it, I felt that I really was someone who represents the grassroots movement in health care delivery in this country in that I am a primary care physician, I am a family practitioner. I started my practice in 1985, which was exactly the same time that managed care hit Albuquerque with a tremendous amount of impact.

I really would like to address two parts of your question. One is what do you think are the successes of HMOs in Albuquerque, and I would like to address these strictly from my point of view as a solo practitioner who has been involved with thousands of hours of volunteer time sitting on committees for three of the IPA HMO models in Albuquerque. The committees have ranged anywhere from the director type of committee to the quality assurance to credentialing, et cetera. So from a point of view, I really have quite a bit of experience along those lines.

The successes that HMOs have had in Albuquerque, I feel, is that they have allowed the businesses that are primarily small in this city to provide health care delivery to their patients, to their employees. The inability to do that very much hamstrings what I am able to do when a patient comes to my office for medical care. When they do not have insurance, I am unable, basically, to do the appropriate tests so that I can provide adequate care.

So it has taken a great deal of the burden of decisionmaking off of me because these people can afford to have health care delivered to them. And I think that is one of the greatest successes of the HMOs in Albuquerque.

The other thing, which is a little more obtuse, is that they have provided us with information that will allow us to be more cost efficient and cost effective in what we deliver as health care. I have never, as a training physician, had the opportunity to look at how much it cost to have a gallbladder ultrasound or a C.B.C. done, et cetera. So during my health care education, I never was allowed to see how much my actual costs were that I ordered when taking care of a patient. So by getting information from these HMOs, I have been able to now figure out when someone comes into my office how I can make tremendous cost savings that still allows me to provide quality care. And that information was not available to me until I participated as a physician in an HMO, and I think it is a very important aspect of it.

It also is one of their negative aspects because as the information was generated to me, it only was on cost analysis and never had anything to do with the patient's outcome, with the patient's satisfaction with me, how I was affording care to them, et cetera. And that is what Dr. Kanig alluded to. Those systems are not in place

and they very much need to be put in place. HMOs are cost driven and that is the bottom line. The quality of care is very often overlooked or never even addressed.

So those are the two major successes that I think have come from HMOs.

On the negative side of the coin, the HMO service in Albuquerque has provided, for the most part, a very, very fragmented and disenchanted group of physicians. Not many will have the guts to stand up and say how intimidated they are, how unhappy they are, and those that ultimately decide they can no longer practice here in Albuquerque, they go on and leave the community. We have had a certain amount of influx of some of the very best physicians in this community leaving because they simply cannot stand the pressures of managed care.

The other and more silent concerns that I have about this discontent, which if you hear nothing else from me today, please hear that there is this discontent. The other negative aspect is, when I enrolled in the University of New Mexico in 1977 as a medical student, I competed head to head with 15 other people for that position. It was highly competitive. There were a lot of people who wanted to go into medical care.

At this particular time, the enrollment, or the competition is 1.5 people to 1 position, and that is the most ominous predictor of what will be coming down to health delivery in this country in the 21st century from my point of view. Primary care is definitely the wave of the future.

I am a primary care physician. I know how well and how cost efficient I can provide health care. If you cannot enroll primary care physicians into President Clinton's plan, it will fail miserably. And our past experience is that that has not been able—this country has not been able to have primary care physicians, and there are a lot of reasons for that that I think this subcommittee also needs to investigate at some other time.

The other part that concerns me deeply is that I am a citizen of New Mexico. I was born and raised in Albuquerque. As part of my packet, you all have some graphs that I hope you pay quite a bit of attention to. It shows in the last year of 1992 approximately $14 million went out of this State in health care dollars that was generated by premiums either that the employers or the employees paid to companies outside of New Mexico.

We are a poor State, as you alluded to, Chairman Towns. We cannot afford that kind of money to go out. And when it does, it really does erode the base that we have for health care delivery in New Mexico.

And I mean that the reason that goes out of State is because our HMOs are not locally owned, with the exception of Health Plus. FHP is primarily a California-based group, and QualMed is a Colorado-based group and First Source, which is Blue Cross/Blue Shield, has a multiconsortium, and Lovelace has some locally controlled leadership but is under the auspices of Cigna. The only one that really is locally controlled is Health Plus, which is from Presbyterian Health Care System.

I also am very concerned in that as a witness today you all look at me as a physician who does not want health care reform and

that is totally untrue. I want to try to develop some quality issues so that when I have an encounter with my patient, they go away feeling that I have genuinely helped them in whatever their health care needs were, and, at the same time, I need to get out from the burden of managed care.

I find it to be very manipulative. I find it to be very obtrusive in the care that I would like to give to my patients. And I feel also that, for the most part, because it is so cost and HMO administrative driven, that the physicians have lost their voice in the process. The voice of us has to be heard loud and clear for Clinton's plan, because I do feel that primary care and what we can do to help in preventive medicine and in mental care, so on, and so forth is going to be the backbone of this program.

Because I am a family practice physician, I do feel I specialize in families and I see that our families in this country are becoming more and more ill for a lot of reasons: A lot of pressures, children who are not cared for, et cetera. And so I do feel that primary care is an area that needs to be looked at, but we cannot continue in managed care the way that it is developing in Albuquerque. Thank you.

Mr. TOWNS. All right. Thank you.

[The prepared statement of Dr. Merovka follows:]

MANAGED CARE: AN IN-DEPTH LOOK AT HMO'S

by

CAROL MEROVKA, M.D.

In 1985 I began my solo practice in Family Medicine in Albuquerque, New Mexico. I graduated from the University of New Mexico's Family Practice Residency in 1984. During the first months of 1985 there was one HMO in Albuquerque ie Lovelace Medical Center which had been quietly enrolling more and more of Albuquerque's citizens in its HMO plan. The "non Lovelace" medical community was becoming increasingly nervous about losing these patients to Lovelace. Into this community, which outside HMO systems considered "ripe", came three HMO systems: 1) Health Dimensions, 2) First Source (BC/BS) and 3) New Mexico Health Plan. And for all practical purposes, Albuquerque's medical community has never been the same and for the most part, has not prospered under these new circumstances but merely survived. And since Albuquerque yearly ranks in the top three communities for HMO penetration, we have survived alot.

Because my practice and HMO's started in Albuquerque the same year, I have been intimately involved with them and have felt keenly their impact on medical care delivery in Albuquerque and especially their impact on the development of a solo family practice. For the purpose of background and hopefully to lend credence to my views, I would like to briefly review my involvement in Albuquerque's HMO organizations. I served on the Advisory Board and Credentials Committee for New Mexico Health Plan, served on the organizational

committee for Cooperative Health Plan which ultimately became Health Plus, Presbyterian Hospital's HMO, served as an original board member of Health Plus's IPA for four years (president elect during the last year of the board's existence) and served as a member of Health Plus' Credential Committee and Chairman of its Quality Assurance Committee. I have spent thousands of hours participating in the policy decisions of these plans and therefore, have seen some of their strengths and weaknesses.

The following is a synopsis of Albuquerque's current health care environment. We have five HMO's with only one being locally owned and managed. The HMO's are: 1) QualMed, 2) HMO New Mexico, 3) FHP, 4) Lovelace and 5) Health Plus. These plans have approximately 50% of Albuquerque's insured population enrolled in them. When you add Medicare, Medicaid, military personnel and their dependents, the VAH system and the Indian Health Service, well over 3/4 of Albuquerque's citizens with health care coverage are in "managed" care. In addition approximately 25% of Albuquerque's citizens do not have any health care coverage at all. These 25% are composed primarily of citizens who work but do not have employer based health care plans, of people out of work temporarily, the homeless and people who chose not to have insurance because they do not want it or they cannot afford it.

This health care environment is driven by the fact that New Mexico is a poor state, ranking consistently in the bottom five for per capita income and ranking number one in uninsured citizens. Albuquerque is New Mexico's largest city but does not have many

large employee businesses. The majority of businesses employ less than 25 people so we doo't have businesses driving the market. Instead we have HMO's driving the market. In 1985 many of Albuquerque's businesses could no longer afford indemity health insurance plans because of premium costs which doubled or tripled yearly. The HMO's initially provided stability of health care costs to these employers who had 25 employees or more. Small business of less than 25 employees still could not enter into the HMO arena because these small groups were not cost effective to the HMO's. During this time the competition was extremely tight with a few dollars deciding who would win or lose an enrollment contract. Average premiums for an individual in 1988 varied from $69.00 to $73.00. Hospitals, physicians, HMO's and patients all were engaged in a learning curve to adjust to the new ways of delivering health care "ala HMO's". Now looking back on all the turmoil from 1988 to 1992, I feel I can address objectively the pros and cons of living with HMO driven health care from the perspective of a "primary care provider".

MECHANICS OF HMO'S

The mechanics of HMO's are primarily governed by rules and policies generated by the owners and administrators of the HMO. They are, afterall, businesses with the power based in the owners and administrators. Basically which hospitals, physicians, laboratories, radiology units, pharmacies and ancillary services used are determined by the HMO. Primarily finances drive these decisions with quality outcomes and convenience having a much lessor role. In some instances the HMO has advisory boards of physicians to help

in these decisions but they are mostly figurehead committees with little policy making roles.

COST EFFECTIVENESS OF HMO's

This aspect of HMO managed care has been highly publicized and valued. Initially to attract members, premiums were very low with a certain financial loss expected the first and possibly second year of existence. Physician fees, hospital reimbursement, laboratory and radiology fees and in some instances, pharmacies were discounted. In addition to the discounted fees, risk withholds were taken out of physician's fees up to 15% of the discounted fee. If there was a surplus, this money was returned to the physician; if not they were kept by the HMO. The pressure on physicians to practice "cost effective" medicine has been extensive and, in my opinion, effective. This is one of the areas where HMO's have had a very positive effect. Computors generate the costs of each patient's encounter with a health care provider. These are available for review by each provider. These fact sheets quickly show the difference a choice of procedure or an antibiotic has on the cost per encounter and rapidly modify practice patterns. In addition information about which speciality groups cost the most and the least per diagnosis code is made available to primary care physicians so referral patterns can be changed. Through these efforts medical costs have been kept down. However, premiums have increased yearly in Albuquerque even though actual medical costs have not increased substantially. The premium increases have gone primarily to share holders in the form of profits. This has a

net effect of taking millions of dollars out of Albuquerque's economy which cannot afford even the loss of one dollar. In addition, FHP has recently contracted all of its laboratory work out of state which also siphons substantial money out of the community. For your information there are graphs attached to this paper showing figures from the New Mexico Insurance Commission about costs, etc. for three of Albuquerque's HMO's. The two staff models, FHP and Lovelace, were not available.

The economics of administering HMO's is staggering to me. Total costs of administration is not actually known in non staff model HMO's because each individual physician's office performs a large number of tasks that are never accounted for and conservatively 2% to 3% of each physician's fee is used for their office's administration. It is not cost effective for each office to collect a minimal co-payment, send an individual bill to the HMO, receive payment, check each individual explanation of benefits, resubmit these when there is an error by the HMO (rate of errors is 50%) and manage problem claims. These expenses are never addressed in the HMO's administrative costs but are very expensive and increasingly more complex.

Therefore, I strongly disagree that HMO's are cost effective in the non staff model setting. By conservative estimates, they use 65% to 75% of collected premiums for actual medical care costs according to their figures from 1992.

HMO MARKETS

The successful HMO's in Albuquerque have learned to disenroll groups that are too costly. They attempt to market and serve the large to medium employer, to obtain the healthy, working citizens and to minimize their risk. They tend to stay away from the smaller employer. The exception to this is FHP who began marketing an individual insurance plan two months ago.

IMPACT ON THE MEDICAL INDUSTRY

This is the most subjective topic for me. The main HMO that has impacted on Albuquerque's medical industry is without question Lovelace. It went after the health care market in Albuquerque with organization and foresight and with the leadership of a physician. Everyone else has played catch up and tried to duplicate Lovelace. This has profoundly affected any other creative approach that might have been advanced. The CEO's of the other competing private hospitals have tried to duplicate Lovelace with marginal success. This competition has destroyed any sense of cooperation, has lead to unnecessary duplication of services (two complete heart programs, two separate cancer programs, two NBICU's) and has lead to an almost "total war" mentality that stifles innovation , exchanges of ideas and a sense of well being. We have become a highly stressed and at times mean spirited medical community. This has impacted on our ability to deliver health care with compassion and sensitivity.

This mileau has also failed to attract new physicians to Albuquerque. Speciality groups have to recruit for sometimes over a

year to get new partners or replace those that have left. Primary care physicians coming into the community can not afford to go into practices other than staff model HMO's or salaried positions with other HMO's and many of these are gone within a year. Physicians are retiring early or leaving town. Those that elect to stay are here because they love Albuquerque and have become tolerant to the way we finance and deliver health care.

This condition is not just the fault of the hospitals and the HMO's by any means. The physicians have not provided adequate leadership out of fear of losing their practices, retaliation by the hospitals for presenting adverse opinions and sheer complacency and laziness. There is too much feeling of impotency here to allow creative leadership to take hold but hopefully that is changing. There is a grass roots movement to become creative and to deliver high quality, cost effective medicine outside of the realm of HMO's.

QUALITY OF SERVICES

The quality of HMO health care is once again subjective. There are no outcome studies available. The overall opinion is that Albuquerque's HMO's range from inadequate to very good. If quality of service is gauged by timeliness of office visits, the staff models have the greatest waiting times for an appointment. Enrollees in these HMO's tend to not see the same provider regularly which can erode the care if medical records are not available. The rapid

turnover of primary physicians also causes patients to have erratic care which can lead to poor outcomes. Centers and physicians which have demonstrated excellence are often not available because they are excluded from a plan. The reverse is also true, ie poor quality providers are used because of their affiliation. These decisions about which providers are included are often arbitrary and without recourse to the physician or patient.

In summary, the HMO's in Albuquerque have had a major impact on health care delivery. For the most part it has been adequate for the patient and marginal for the hospitals, physicians and ancillary providers. In my opinion the system is not cost effective as first proposed. It has evolved to being almost equal in premium costs to indemity insurance. It has also blunted creative thinking to help solve the major issues of health care, ie access, cost and quality for all citizens.

HEALTHPLUS

	1992	1991	1990	1989	1988	1992	1991	1990	1989	1988
PREMIUM (000)	46703	36525	28675	27017	22717	100%	100%	100%	100%	100%
PHYSICIAN (000)	20259	15438	12278	11779	10590	43%	42%	43%	44%	47%
HOSP	15618	12466	11519	10478	9737	33%	34%	40%	39%	43%
TOTAL MEDICAL (0	36038	27792	23271	22714	21019	77%	76%	81%	84%	93%
ADMIN (000)	9120	7033	5449	5027	4106	20%	19%	19%	19%	18%
NET INCOME (000)	2102	2236	437	233	-1444	5%	6%	2%	1%	-6%
MEMBER MONTHS	481495	393968	319118	324264	313311					
PHYSICIAN ENCOUN	161208	126612	105288	107425	133371					
INPT DAYS	11054	9651	9383	8263	10204					

PMPM ANALYSIS

PREMIUM (000)	97.00	92.71	89.86	83.32	72 97
PHYSICIAN (000)	42.08	39.19	38.47	36.33	34.02
HOSP	32 44	31.64	36.10	32.31	31.28
TOTAL MEDICAL (0	74.85	70.54	72.92	70.05	67.52
ADMIN (000)	18.94	17.85	17.08	15.50	13.19
NET INCOME (000)	4.37	5.68	1.37	0.72	(4.64)

PER VOLUME ANALYSIS

PREM PER MEMBER/MO	97 00	92.71	89.86	83.32	72.97
PHYSICIAN/VISIT	125.67	121.93	116.61	109.65	79.40
HOSPITAL/PT DAY	1,412.88	1,291.68	1,227.65	1,268.06	954.23

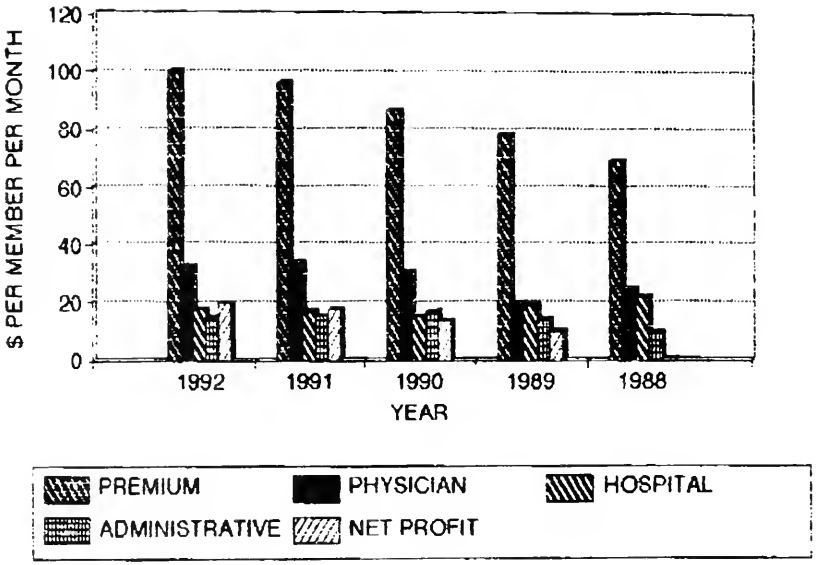
HMO NEW MEXICO

	1992	1991	1990	1989	1988	1992	1991	1990	1989	1988
PREMIUM (000)	19740	14639	12811	8519	9649	100%	100%	100%	100%	100%
PHYSICIAN (000)	4544	3373	3527	2607	2759	23%	23%	28%	31%	29%
HOSPITAL (000)	4910	3958	4032	2913	3515	25%	27%	31%	34%	36%
TOTAL MEDICAL (0	12814	10132	9738	7325	9944	65%	69%	76%	86%	103%
ADMIN (000)	2361	2165	1772	1782	2184	12%	15%	14%	21%	23%
NET INCOME (000)	4943	2540	1473	-374	-1151	25%	17%	11%	-4%	-12%
MEMBER MONTHS	182471	147367	142081	102023	130836					
PHYSICIAN ENCOUN	48576	50777	45025	21905	28368					
INPT DAYS	4368	3674	3473	2603	3368					
PMPM ANALYSIS										
PREMIUM (000)	108.18	99.28	90.17	83.50	73.75					
PHYSICIAN (000)	24.90	22.89	24.82	25.55	21.09					
HOSPITAL (000)	26.91	26.86	28.38	28.55	26.87					
TOTAL MEDICAL (0	70.22	68.75	68.54	71.80	76.00					
ADMIN (000)	12.94	14.69	12.47	17.47	16.69					
NET INCOME (000)	27.09	17.24	10.37	(3.67)	(8.80)					
PER VOLUME ANALYSIS										
PREM PER MEMBER/MO	108.18	99.28	90.17	83.50	73.75					
PHYSICIAN/VISIT	93.54	66.43	78.33	119.01	97.26					
HOSPITAL/PT DAY	1,124.08	1,077.30	1,160.96	1,119.09	1,043.65					

QUAL MED

	1992	1991	1990	1989	1988					
PREMIUM (000)	31018	25026	20954	10186	21851	100%	100%	100%	100%	100%
PHYSICIAN (000)	10080	8719	7318	2534	7754	33%	35%	35%	25%	35%
HOSPITAL (000)	5404	4417	3718	2449	6813	17%	18%	18%	24%	31%
TOTAL MEDICAL (0	20827	16695	14008	7264	19053	67%	67%	67%	71%	87%
ADMIN (000)	4379	4002	3962	1818	2952	14%	16%	19%	18%	14%
NET INCOME (000)	6106	4559	3268	1316	157	20%	18%	16%	13%	1%
MEMBER MONTHS	309202	260694	241428	129747	314309					
PHYSICIAN ENCOUN	100000	82026	70998	19019	0					
INPT DAYS	5434	6327	5114	2542	0					
PMPM ANALYSIS										
PREMIUM (000)	100.32	96.00	86.79	78.51	69.52					
PHYSICIAN (000)	32.63	33.45	30.31	19.53	24.67					
HOSPITAL (000)	17.48	16.94	15.40	18.88	21.68					
TOTAL MEDICAL (0	67.36	64.04	58.02	55.99	60.62					
ADMIN (000)	14.16	15.35	16.41	14.01	9.39					
NET INCOME (000)	19.75	17.49	13.54	10.14	0.50					
PER VOLUME ANALYSIS										
PREM PER MEMBER/MO	100.32	96.00	86.79	78.51	69.52					
PHYSICIAN/VISIT	100.88	106.30	103.07	133.24	ERR					
HOSPITAL/PT DAY	994.48	698.12	727.02	963.41	ERR					

QUAL MED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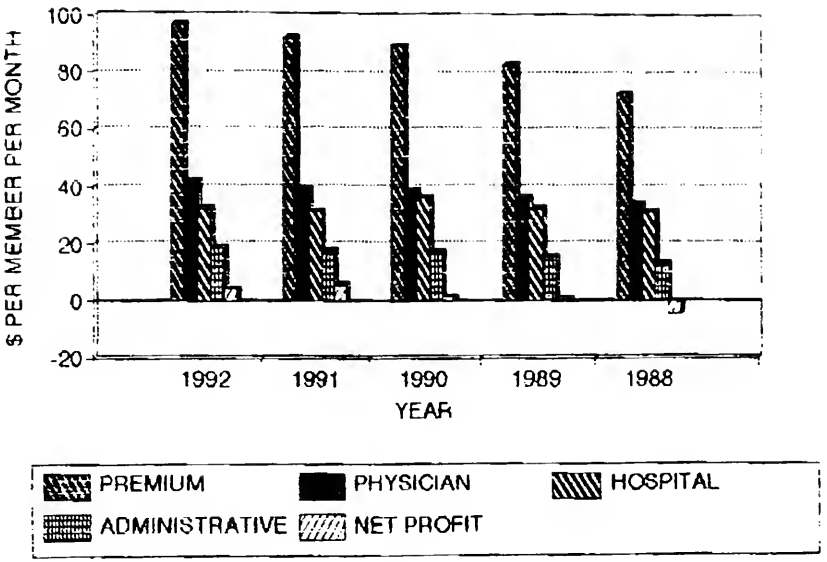
HEALTH PLUS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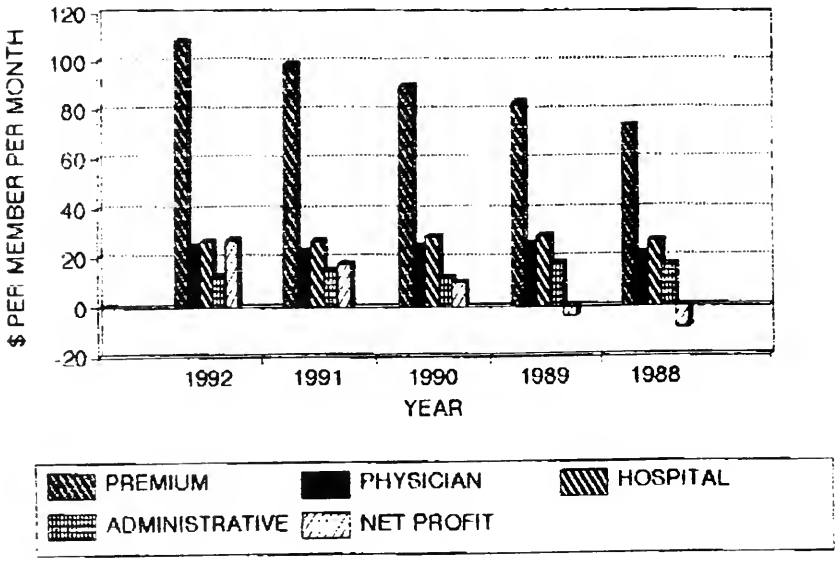
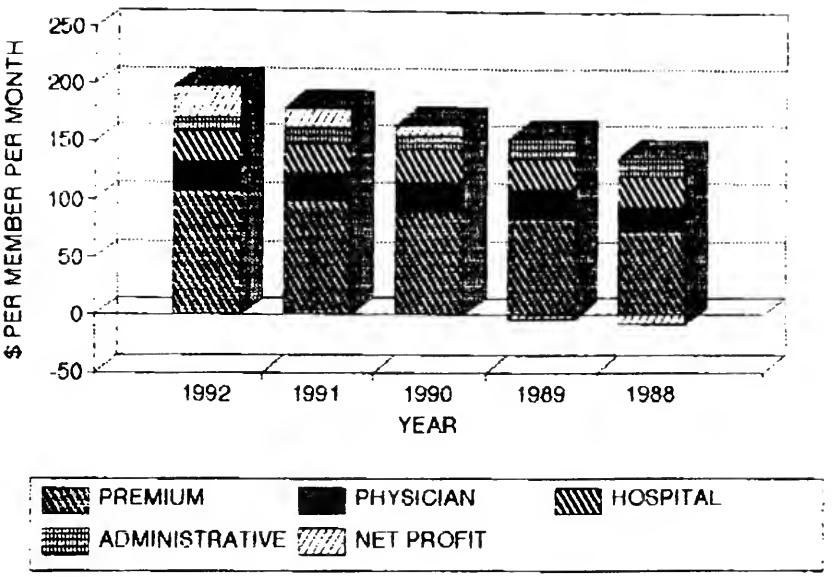
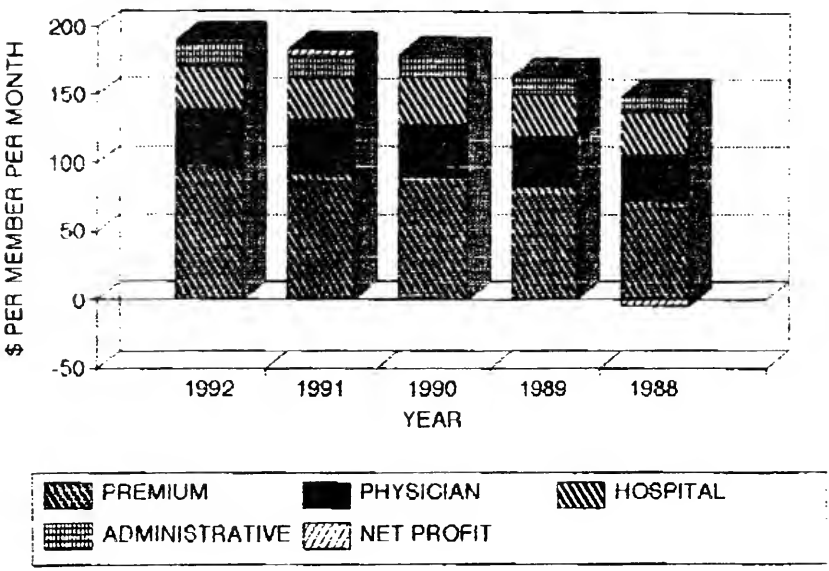
HMO NEW MEXICO



HMO NEW MEXICO



HEALTH PLUS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Mr. TOWNS. Mr. McKernan.

STATEMENT OF STEVEN McKERNAN, CHIEF FINANCIAL OFFICER, UNIVERSITY OF NEW MEXICO HOSPITAL CENTER

Mr. MCKERNAN. Thank you, Chairman Towns, thank you, Representative Schiff, and thank you, Representative Mica. I would like to make some summary comments.

My name is Steve McKernan. I am the chief financial officer of the University of New Mexico Hospital and my comments represent the University Hospital's in how we deal with HMOs.

We are a public teaching hospital, so we support both a public mission, have large public clinics and provide access to essentially anybody that walks in our door through the emergency room in the clinics, and we also provide a teaching venue for the students and residents at the University of New Mexico School of Medicine.

As our system has developed, we have entered into contracts with all the HMOs in New Mexico and provide tertiary care to all the HMOs in New Mexico. One of the issues that we see developing in this is that the government, through the local government and the State government, does not provide the total amount of financing necessary to cover the cost of the uninsured patients that we currently treat.

As everybody is aware, we participate in cost shifting, like most other facilities in health care do, and we use the moneys from Medicare, Medicaid and private insurance, to cross subsidize the cost of care we provide to the uninsured.

When we have entered into the contracts with HMOs, what we find is it is very difficult to get an extra premium negotiated into those contracts so we can use some of that money to help pay for the cost of the uninsured. So what we see going on in the market right now is the HMOs are able to avoid the cost of the uninsured in the ways that they negotiate contracts with the providers.

A similar issue is occurring in the venue of medical education. As a teaching facility, we are required to pay for the cost of residents who see patients at our facility, and the other costs that are inherent in running a teaching facility. Our clinics take longer to run, there are more costs in terms of tests and supplies and those types of things.

Again, when we negotiate our contracts with the HMOs, the HMOs are very, very resistant to including an extra cost when—and we are not permitted to pass that along to the HMOs to cover the cost we have inherent in our facility with teaching, the cost of the residents and the other costs. So as we see the market developing right now, the HMOs have a cost advantage over other providers, some of which is because they are able to factor out other costs that other providers must have in their premiums.

What we would like to see—we are not against health care reform in financing, but we think it will be very important to take into account the cost of the uninsured in medical education when things are put together. Thank you.

Mr. TOWNS. Thank you.

[The prepared statement of Mr. McKernan follows:]

MANAGED CARE AND UNIVERSITY HOSPITAL

There are a number of issues with Managed Care and HMOs that become problematic for any teaching hospital, especially those with large public hospital missions. The University Hospital is a supporter of the managed care concept with access for patients through a primary care provider. The University Hospital understands that capitation will play a big part in health care financing in the future and we are ready to adapt to that method of financing.

This paper will deal with the issues of adverse selection, medical education and cost shifting. We think that HMOs have been able to operate at a lower cost because they are not fully involved with certain issues of health care financing.

The first issue deals with the uninsured having access to health care. Our Hospital, with the assistance of tax support from Bernalillo County and the State of New Mexico, provides care to any person who visits our facility. We treat the patients regardless of their ability to pay and deal with the financing of the treatment for those who do not have an identified third-party payor through a variety of methods. The subsidies that we receive from the government do not cover the full cost of uninsured care, so the hospital is involved in cost shifting to make up the shortage.

HMOs require payment in advance. HMOs normally provide coverage through employer groups which provide a steady source of revenues. Both of these mechanisms provide a process of selecting certain classes of patients into the HMO and selecting other classes of patients away from the HMO. This leaves the uninsured to be cared for by public clinics and hospitals.

Many of the uninsured have social issues that makes the cost of their care higher than dealing with insurance and HMO patients. Transportation is many times difficult for the patients. Our Hospital has problems discharging patients in a timely manner, because they have no family members to transport them. Many of the uninsured also have a difficult time getting to our facility, so their diseases may be more complicated when they first arrive for treatment, which adds to the cost of treatment. HMOs have a tendency to select patients that do not have the same proportion of social issues that the uninsured have and are able to deliver care for less cost for themselves, while other institutions are saddled with the cost of taking care of the more difficult cases.

Because the University Hospital is a teaching facility and provider of last result, it must make available tertiary care services, such as neonatology, burn and trauma services. We are involved in providing these services to HMOs through contracts. In our contracting, the HMOs are very resistant to paying any

extra premium to help cross-subsidize indigent care. Uninsured patients normally do not have very good access to HMO facilities and providers and HMOs do not participate in the cost shifting that occurs to help pay for the cost of uninsured care.

As a teaching facility, the University Hospital has obligations to pay for the cost of residents that serve patients in our facilities. The government through the Medicare and Medicaid programs participate in the payment for medical education through the Graduate Medical Education reimbursement program. When the hospital negotiates reimbursement from HMOs, the HMOs will not reimburse the hospital for costs associated with medical education. For other private indemnity insurers, the hospital is able to use cost shifting to cover the costs not reimbursed by the government.

It is obvious that cost shifting plays a major part in the financing of health care. The University Hospital relies on cost shifting to cover the cost of care not paid for by local and state government sources. The HMOs have been successful in participating in cost shifting when they purchase health care from other providers. This forces facilities like University Hospital to place a higher burden on the non-HMOs to cover the cost of uninsured care.

We do not agree with the current method of financing and would like to see all payors put on an even footing in terms of payments. We are concerned that while health care financing is being reformed in the near future, that more people are enrolled in HMOs. The HMOs will negotiate even lower rates with the providers, and remove our ability to finance care to the uninsured.

Mr. TOWNS. Let me thank all of you for your testimony.

As I indicated early on, I think it is a very timely subject and there is no question about it, we have some serious problems that must be addressed. We are in a country that can put a man and woman on the moon over the weekend and we should be able to do something about the health problems we have in this country.

So at this time, on that note, I would like to yield to the ranking minority member, Mr. Schiff, and allow him to start the questioning.

Mr. SCHIFF. Thank you for that courtesy, Mr. Chairman.

First of all, I want to say thanks to all the witnesses. I think you all provided not only very strong testimony but balanced testimony. I think every witness here tried to stay along the lines that here are some positives and here are some negatives about HMOs and we are going to lay them all out.

I have some questions to ask—and I want to stress this before I ask them, because I don't want to be misunderstood, particularly because I live in this community and I am going to be here tomorrow or the next day or at least next week or something. I want to raise some questions that have been raised on the negative side of some of the things that I have heard so that the witnesses can have a chance to respond. So I am deliberately being a devil's advocate in some of these questions and wish to be recognized as such.

Dr. Merovka, you said a major point you wanted to make is there is a great deal of physician discontent here in the community. I have heard that quite a bit. But I notice that Mr. McKernan brought out the fact that, frankly, the HMOs are tough bargainers when it comes to sitting down and negotiating prices. One can argue that is a positive step toward cost containment. In fact, one can argue that cost shifting—you know, one of the problems of cost shifting, I thought, were well outlined by the President in his speech, even if I disagreed with some other points the President made, and there is a question about whether somebody should be expected to provide cost shifting responsibilities.

I would like to ask you this. Is the physician discontent, if you were to generalize it—because I realize we are talking about many, many individuals here. Is it based upon a concern about the quality of the care that patients receive from HMOs; or is it based upon the fact that the physicians, especially the specialists, now have to negotiate with a very informed, if not, shall we say shrewd, group of business people who have a strong purchasing power in terms of leverage in the negotiating process? Something a bit new, I suspect, to the medical community here. Which is more the basis for the discontent?

Dr. MEROVKA. I think that—I hope you can hear me—can people hear me?

Mr. SCHIFF. Can you hear OK in the back?

Dr. MEROVKA. OK. It is really incredibly multifactorial. Again, I have become really a physician activist because I think it is so important, because I really truly love medicine so much, and I consider it to be a privilege to take care of people. But the discontent is mostly because there is so much intrusion on our day-by-day life that no one who does not run a doctor's office has no idea what it is about.

That intrusion is, for example, every time I see an HMO patient, I have to have a bill that I send to an HMO and then that HMO has to reimburse me and my staff has to look at it and see if the reimbursement is correct, and the process goes on and on. When we have—there have been decisions made which totally unilaterally impact how we can take care of our patients.

I will give you one example. One of the HMOs has decided that there is going to be a large population of radiologists that are no longer available for us to use. This happens to have been the only outpatient radiology group that was active in Albuquerque. So what happens now is that I have to interface to try to get an x ray or a study done with a hospital radiology unit which is already overwhelmed by the number of patients they have.

I spent 45 minutes on Friday trying to get an ultrasound done for a patient of mine. That is 45 minutes of my time.

Mr. SCHIFF. An HMO patient?

Dr. MEROVKA. Yes. That was 45 minutes of my time that should have been used in seeing patients and doing more appropriate care. That is one aspect.

I don't think any of us in this town really disagree with fee setting. That is not the issue. The problem is that the fees, as you know, from Medicare, trying to do a relative value, are still incredibly ineffective, in that primary care people are still not given an adequate reimbursement for their time simply because it is considered to be cognitive time, and still giving way too much in the way of reimbursement for certain things they do.

There has to be more equity. And I am not a specialist basher by any means. I look at this as a team and it is a wonderful team that is actually being serviced in Albuquerque. HMOs really have driven primary care more to the forefront, so it is that intrusion. I don't think the fee is that much of a problem because we are all making a good wage. It is not as good as it used to be, and we are working much harder for that wage, but still we are making a good wage.

But the other way, whether it is true or not, discontent, people are not listening to us and that they don't care. It is all bottom line. And we feel that we have lost that bridge between the patient population that we want to serve and perhaps even businesses so that—and there is a lot of discontent. There is a group of physicians now that are coming together as a coalition that if you would have asked me 3 years ago if these people would sit down at a time table and talk, I would have told you unequivocally no. They are coming together to try to figure out how we can start getting some control back.

Physicians have been very much at the lower part of this learning curve. And, you know, we are bright people, but we are not necessarily bright in the area that you want us to be bright in right now. But the Albuquerque community, I will tell you, is on an exponential learning curve and we have learned that we have to be cost effective in order to survive. And, more importantly, we want to be cost effective. It is no longer an exercise, it is something we genuinely want to be.

So I really don't think it is the fees that are driving it. I think it is all this other administrative stuff that is driving us crazy.

Mr. SCHIFF. Before asking any other panel member if they want to respond to that question, which they may or may not choose to do, Mr. Chairman, Dr. Merovka mentioned a point which I suggest, not for today but for a future hearing, on the subject of Medicare and Medicaid reimbursements of physicians and hospitals. Since the President made correctly, I think, such a major issue of cost shifting, we should study the effects of the low reimbursement rate by our own present government programs on that cost shifting at a future time.

Before I do go on to the next question——

Dr. MEROVKA. May I make one more point?

I was very happy that Mr. McKernan talked about the fact that HMOs are not at all involved in the indigent and unpaid population. The hospitals, the physicians bear a tremendous burden of that here in Albuquerque because we have so many people who are not insured. And that is a hidden cost that is impacting again on all of us, which is another reason there is sort of this underlying discontent in Albuquerque.

But, more importantly than that, I don't think the HMOs understand how much free care they get from us either. Because a lot of the time we get such a low reimbursement, but because we still care in this community that we give good care, we will take what reimbursement that is and we will do within our heart what we think is right.

And, in addition to that—I have lost my point—we are trying hard to still do what is right but that is never factored into the HMO. There is a lot of free care given even within the HMO population. And—oh, the point with Mr. O'Brien about 81 percent of the people being satisfied with their HMO coverage, it is because we are still really trying and we are trying very hard that patients still want to come to us and we still have a good rapport with our patients. So a lot of that content that people have is still because the physicians in this community are trying very hard.

Mr. SCHIFF. Any of the other witnesses want to respond to that question before I go on to the next?

Mr. O'Brien, since you are here representing managed care, the HMOs.

Mr. O'BRIEN. Yes.

Mr. SCHIFF. I have three or four things I would like to ask you about. Once again, I stress these are things I have been told and want to give you a chance here to recognize them.

The first is the out of New Mexico effect of HMOs. It is my understanding of the five—I believe five. Again, am I correct on that figure? Five active HMOs in the Albuquerque area, as stated by Dr. Merovka, four are owned outside of the State of New Mexico?

Mr. O'BRIEN. That is not true. HMO New Mexico, which is the new name for First Source, is owned by Blue Cross, which is a New Mexico corporation. Blue Cross of New Mexico is involved in merger dialog with Colorado but it is still a New Mexico corporation that owns HMO New Mexico.

Mr. SCHIFF. So of five HMOs in this area——

Mr. O'BRIEN. Two are owned and controlled locally. The other three are owned outside by publicly held corporations, Cigna, FHP, and QualMed, which is a Colorado corporation.

Mr. SCHIFF. Is it correct at least one of these HMOs has decided recently to have tests done by laboratories outside of New Mexico, so a large amount of work and, therefore, income, that was formerly done here in New Mexico to support New Mexico-based health care facilities, is now being done outside the State?

Mr. O'BRIEN. I don't know that for certain, Congressman Schiff, but it would not surprise me and it is not necessarily reflective of the issue of ownership but more, I am sure, of the issue of cost and effectiveness.

Mr. SCHIFF. But if work is taken away from New Mexico laboratories, it makes it difficult to stay in business here to support others who are trying to still use them, doesn't it?

Mr. O'BRIEN. As we talk about their contracting relationship of a price and an agreement to provide a service for that price, that really gets to the very issue that you are talking about.

If an Arizona laboratory is going to provide it at X and it is X plus something in New Mexico, the economics really begin to dictate the process.

Mr. SCHIFF. And if a New Mexico laboratory goes out of business because it does not have enough remaining work, don't you think that has an effect on health cost?

Mr. O'BRIEN. Without a doubt, but the market forces are ruthless in terms of managed competition. As we move toward that, there are forces that you need to deal with in the marketplace that create the realities of what you do.

Mr. SCHIFF. Well, if we are talking about market forces, let's also talk about the profit motives. Of these five HMOs, how many of them are for-profit enterprises?

Mr. O'BRIEN. I believe they are all organized now, technically, for profit, including the Blue Cross subsidiary.

Mr. SCHIFF. What was the profit margin of each of the HMOs, or an average between them, say, in the last couple of years, do you know?

Mr. O'BRIEN. Probably over the aggregate 4 or 5 years it would be single digit. Probably 6 percent. I know there were losses in 3 of at least the last 5 years by most of the HMOs.

Mr. SCHIFF. Couldn't that be argued as startup cost, as in any business? If I were to ask you what the profit was for each one in the last fiscal year they all closed, what would that be?

Mr. O'BRIEN. I don't have those numbers, I am sorry.

Mr. SCHIFF. Would you be willing in the next 10 days to provide us those numbers in writing, if I could ask you to do that?

Mr. O'BRIEN. Absolutely. Yes, I can.

Mr. SCHIFF. A core issue of HMOs, perhaps the core issue, is not simply cost containment, though it is a legitimate issue, but cost containment without compromising the quality and quantity of health care. And I heard a couple of things said that I would like to ask you about for your response, one of which is that in some way, and I am not an expert on the mechanics, if in fact this is true, in some way primary physicians who are employed full time by HMOs are eligible to receive at the end of the fiscal year a bonus, if you will, out of a certain amount of money that is set aside for further treatment of patients of HMOs, presumably by specialists.

So, in other words, the more specialized treatment that in fact is authorized by these primary physicians, the more this pot of money goes down and the less there is available for them at the end of the fiscal year. Are you clear on what I am talking about? Is this a correct statement?

Mr. O'BRIEN. Yes, that is a fairly accurate reflection of most of the IPAs, in terms of their payment scale.

Mr. SCHIFF. IPA?

Mr. O'BRIEN. Independent practice affiliate. HMOs, as opposed to staff models, where physicians are on salary.

Most of the IPAs deal with a withhold-created bonus pool. And the distribution of that varies among the HMO formats.

Mr. SCHIFF. I am sorry, back up with me, Mr. O'Brien. Tell me again what an IPA is, please.

Mr. O'BRIEN. Independent practice association or affiliation.

Mr. SCHIFF. That is a physician in private practice who has joined——

Mr. O'BRIEN. That has joined a nonconstruction-oriented HMO. That would be HMO New Mexico, QualMed, FHP.

Mr. SCHIFF. I understand. But they are not full time——

Mr. O'BRIEN. They do not represent the particular HMO exclusively. They may represent all of them or four of the five.

Mr. SCHIFF. I understand. They are eligible for what now? Would you explain that?

Mr. O'BRIEN. It is a withhold-generated bonus pool. A fee schedule is established in which they may receive a varying amount, 80 or 90 percent of the fee schedule, with the balance being put into a pool. That pool will then be used for distribution based on outcome. And they are typically not only financial measures, they are typically some quality measures as well on that physician's overall profile.

But the big kick is, obviously, the specialist and hospital referral patterns of the physician.

Mr. SCHIFF. So, in other words, there is a financial reward for the IPAs, as you described them——

Mr. O'BRIEN. Yes.

Mr. SCHIFF [continuing]. If, based upon a profile, to quote you, in which the big kick is the effect on the use of specialists.

Mr. O'BRIEN. Specialists, hospitalization as well as care characteristics for the patient.

Mr. SCHIFF. So the less that they recommend the use of specialists and hospitals and so forth, the more money they will make?

Mr. O'BRIEN. Potentially.

Mr. SCHIFF. Isn't that one heck of a conflict of interest?

Mr. O'BRIEN. It can be. It is a difficult one for most physicians to deal with.

Mr. SCHIFF. Pardon me? It can be? I think it is. Is there any doubt telling someone——

Mr. O'BRIEN. I don't think physicians treat their patients, as Dr. Merovka said, they provide a fair amount of free care, and I think that is part of what she is talking about.

Mr. SCHIFF. The bottom line, though, is the less medical service they recommend in these areas, potentially the greater their personal income can be?

Mr. O'BRIEN. Correct.

Mr. SCHIFF. Mr. Chairman, just because of the hour and we need to get going so we can hear more witnesses, I would like to yield back at this time.

Mr. TOWNS. Thank you very much. At this time I would like to yield to Congressman Mica.

Mr. MICA. Thank you, Mr. Chairman.

What I would be interested in is what elements you see missing in managed health care or these HMOs which could be incorporated—we are looking at expanding what you are doing to a much larger extent. You have experience. Some of it appears to be fraught with problems also. Sort of mechanical processing that is forced on you and the patients and the incentives that are more to push people through the system. I don't want to say for profit but just to keep the thing going.

Dr. Merovka, maybe you could give me some ideas on how we could improve this?

Dr. MEROVKA. Well, I think one of the main reasons—one of the main ways it can be improved is that something that every HMO has no idea about is how much administrative cost for each HMO is dependent on the physician's office. It is tremendous. So that needs to be cut down.

Mr. MICA. What would you compare it with? Do you also treat Medicare or Medicaid patients? Because that is another paperwork nightmare.

Dr. MEROVKA. Let me give you an idea of the makeup of my practice. I am one of the few physicians in Albuquerque who has still been able to maintain fee-for-service. I only belong to one HMO, although I belonged to all of them initially but was so—I was cracking under the burden of all of them so I had to make a decision which to choose, so I chose one.

I believe very strongly in having a mix within my practice. Otherwise, I will not be able to keep my doors open and I will have to leave and practice someplace else. So I have Medicaid, which gives me a very, very poor reimbursement, and is a large amount of the thing, and I consider that to be free care because a lot of the times I don't ever get reimbursed for it. I feel strongly that I have a moral obligation to this State to take care of Medicaid patients, and so I still see patients that are Medicaid. So that is sort of a loss leader for me as far as my finances.

I see Medicare. I am not a participating physician, because I feel that most of my Medicare patients have a supplement and can give me as much as I can eke out. But I still have a lot of people who come in my office who do not have insurance who are fee-for-service and who pay my regular fee.

But I know managed care is coming down the road. I was privileged to be part of Senator Bingaman's hearing when he came to Albuquerque earlier this year, and I asked his counsel if I was going to be able to survive in Clinton's system as a primary care solo practitioner? And he looked me straight in the eye and said no. So I will have to integrate with all the HMOs on a greater scale than I am now, and the one thing they have to do from my point of view is that they have to cut down the incredible amount of repetitive, repetitive administrative costs in my office.

Mr. MICA. Is that mostly paperwork?

Dr. MEROVKA. Paperwork, calling for referrals, calling for authorizations, trying to get special services for my patients.

There are times that I go to bat for my patients. They need care the HMO will not provide and I have to talk to the medical director. I have to write a letter to the medical director trying to make a case for my patient that has to have something. The layers of administration on HMOs are formidable, and that is the one area you all need to look at in depth.

Mr. MICA. So every case sort of becomes an administrative Waterloo and you have to fight each battle?

Dr. MEROVKA. Right. And if you look at the graphs I provided that actually came out of the insurance commission, and you will look all the way across the actual medical costs that are provided either to the hospital or to the physician, for most of the HMOs they are a straight line. It is the premiums that have gone up.

And that is another thing I think needs to be looked at, is that if you are going to keep the cost—we have been tightened down with the screws as tight as we can possibly go in this community and yet the premiums have continued to go up, as has the profit margin for every HMO. That is part of your packet, Congressman.

Mr. SCHIFF. Mr. Mica, if you would yield for one second, quickly, because it is not my time?

Mr. MICA. Be glad to.

Mr. SCHIFF. You mentioned the idea of administrative savings. And the HMOs believe, as Mr. O'Brien testified earlier, that I think the idea of a connected managed care system lowers administrative costs.

Can I just ask Mr. O'Brien, and any of the other witnesses, if there exists any kind of study that demonstrates, on the administrative side, the cost that is not actually there between physician and patient, if there is any kind of study that indicates that HMOs in fact are administratively more efficient than other types of organizations?

Mr. O'BRIEN. I don't know that there are any real definitive studies. Everyone defends administrative costs in different ways. When you get into the cost at the provider level as well as the carrier or HMO level, I doubt that anyone has really done—we have some great JAMA information on the provider side, we have some administrative cost information on the HMO side in aggregate, but I don't know that we have really gotten to the point of putting those two together to create real numbers on absolutely administrative costs.

Mr. SCHIFF. Thank you, Mr. O'Brien. Yield back to Congressman Mica.

Mr. MICA. I wanted to ask two other quick questions.

One, Dr. Merovka, the quality question. How do you maintain quality in this whole process, quality of care? What would you recommend to us that we institute in the way of something that has quality assurance, rather than filling out——

Dr. MEROVKA. Again, I have sat on countless committees for three of the HMOs in this city in regard to just that issue, and we have a utilization review committee which looks into outliers. They are physicians who the HMO has identified through their comput-

ers are costing too much, and they have never looked at physicians who are costing too little.

And that refers to Congressman Schiff's thing, is that the fact of the matter is the quality issue is still very much dependent on the quality of the physician. It is so subjective.

Mr. MICA. That is the problem, then. How do you write government rules and regulations?

Dr. MEROVKA. On subjective things? I don't really think you can do that. What you have to do is to look at the education of physicians, and that is being looked at throughout the country.

The University of New Mexico is one of the leaders in that area. We have to be taught during our education to be community-based physicians that understand what "quality" is. I think quality is that people don't die, for one thing, obviously; that people don't have high rates of morbidity because their care has been withheld or been inappropriate.

But one antibiotic versus another one, ultrasound versus another, et cetera, those studies are not available and, hopefully, with the giant supercomputers we are getting, we will be able to generate that data.

But the quality is still based on the physicians that each HMO contracts with. And there are some HMOs in the community who are generally considered to have very poor quality providers. There is a constant turnover. People may have one physician who only stays for a few months and then he is gone. These are primarily staff model types of HMOs, and we have no way of looking at that and that is one of the big things.

The big buzz word in health care right now is outcome information. We don't really have that, and so the quality issue is basically based on mortality and morbidity, which is not generated by HMOs.

Mr. MICA. The other question I had, and this is my final one, Mr. Chairman, is that I think you mentioned futile care, Dr. Kanig, and maybe I am not familiar with as many of these medical terms, but is that the care at the end of life where there is not much hope? Is that what you are referring to?

Dr. KANIG. Yes.

Mr. MICA. That is another problem we have to address, because now, as I recall the statistics, we are spending incredible amounts of money, almost 60, 70 percent of the Medicare cost is at the end of life. We have the ability to sustain life, and the bill just sort of runs on and on, and as long as you can keep the meter running, you go on and on with these heroic measures, which is another societal legislative problem we face. And I just wonder what you recommend there?

Dr. KANIG. I think society needs to deal with the fact that at this point people expect that they can demand care even in the face of medical evidence that the care is not going to prolong useful quality of life.

For example, I take care of patients who are on dialysis, who live in nursing homes, who are incredibly demented, who have a very poor quality of life, who, if they could tell me stop my care, they probably would. But there may be a guilty daughter who lives

2,000 miles away who says, oh, no, I couldn't live with myself if you let my father die, keep him alive.

Sometimes that happens with patients who are in the ICU who are eating up thousands and thousands of dollars a day, who there truly is no hope for whatsoever, and physicians do not have the ability to say, no, this is inappropriate, we will stop care. There is the fear of malpractice litigation if we did so in violation of the family's wishes, and there are no principles that have been set up to allow us to do that easily.

Although, I must say, that recently I guess there have been a number of legal precedents where futile care has been successfully denied.

If I might also make another comment in reference to your earlier question, Congressman Mica, in terms of quality. I see one of the issues that may hinder quality, the overriding emphasis on the short-term bottom line. All of these organizations, through no fault of their own, have to economically survive, and that means they have to look at what their bottom line return is going to be 6 months or 1 year from now.

When we look at quality of care for patients, particularly those with chronic illnesses, like diabetes, we are not looking at saving money in 6 months or 1 year, we are looking at saving money and making those patients healthier 5 to 10 years from now. If I take care of a diabetic patient, I know with strict control, which is going to take a lot of time and resources and effort, and it will cost more money in the short term, I might make it much less likely that that patient 5 years from now will be blind or on dialysis or having his leg amputated. But in the short term that will make me look like a relatively less cost-efficient physician because I will be spending more money taking care of that person.

The system has to be reengineered to allow the long-term prospective on care of patients. I should not have to worry that I will suffer economically if I were part of a system that did capitate me based upon my cost profile if I do what is necessary to take the best quality care of my patients now.

And there are a number of physicians right now who are in the conflict of interest situation that Congressman Schiff alluded to where they do know they may suffer financially themselves if they did spend the extra money taking the best care of their patients. And that is an awful situation for physicians to be in.

Mr. MICA. Thank you.

Mr. Chairman, I yield back.

Mr. TOWNS. Thank you, very much, Congressman Mica.

Let me just ask a couple of questions. I will begin with you, Doctor. I know you are not a lawyer, but you mentioned tort reform, and I must admit that that is a real concern.

Do you have any ideas about what we might be able to do? Because you talked about defensive medicine and that further drives up the cost. What can we do legislatively that might be able to relieve some of the burden?

Dr. KANIG. You are right, I am not a lawyer, and I don't consider myself an expert in the area, but I know there are a number of things that have been talked about.

I think having a situation where there can be unlimited contingency fees, where frivolous lawsuits are encouraged because there is no penalty for frivolous lawsuits, promotes litigation. There are more and more lawyers who are joining the plaintiffs' bar. If there were, for example, a system where the losing side had to pay the legal cost of the winning side, I think we would see a disappearance of a large percentage of frivolous lawsuits.

I think if there were caps on noneconomic damages, as California has imposed, that too would decrease some of the lottery aspect of the malpractice system.

Having a system that—Carol, perhaps you can make a few comments here, too, as well—the collateral source rule, for example, where patients can get, or plaintiffs can get paid from more than one source needs to be changed.

Do you have something else?

Dr. MEROVKA. And I think there are so many hidden costs in how much the fear of malpractice, et cetera, impacts on medicine. Definitely each and every one of us wants to provide care that does not ever lead to a malpractice suit, but it is very important that there not be these huge, huge claims for people in and above all their medical care costs, which are already being taken care of.

It is the fear of that that makes physicians do a great deal of inappropriate testing, and we are always afraid and we are always covering our backs and so on and so forth. And so at some point in time you have to really be able to gain the mentality that you are going to practice medicine and the chips will fall as they may.

But there are other hidden things none of you all know about. For example, every time I buy immunization to give to one of my patients to keep their immunizations up to date, there is a huge amount of money that goes into the company's fear of legal intervention. I just had a surcharge of $5 added to each immunization that I purchase simply for the fear of litigation by Merck, Sharp & Dohme.

Mr. TOWNS. Say that again.

Dr. MEROVKA. I just had $5 added to the cost of each immunization that I purchase from Merck, Sharp & Dohme, which is a pharmaceutical company, strictly for their legal fee bank so that they, if they have a large $6 million, $10 million judgment against them, they have this $5 fee that I pay and then I pass on to my patient for the threat of malpractice.

That cost is spread throughout the whole medical system. There are hidden costs that none of us—and the only reason I know about that is because I got a bill stating that the reason my measles, mumps, and rubella immunization went up $5 was because they needed to have this extra fee for their litigation fund.

So it is everywhere. You all have no idea of how much it permeates what we do and how much it increases costs throughout this country for health care delivery.

If you look at Clinton's program, he wants very much preventive care, and I practice preventive care as a family practitioner, but it is very difficult. Somebody comes into my office and I charge for three immunizations, which is basically my cost—I don't charge anything extra for it—$75.

Mr. TOWNS. Let me make sure I clearly understand you. You are saying that they indicate that we have to charge you an extra $5 just in case there is some litigation——

Dr. MEROVKA. Right.

Mr. TOWNS. That we will have the extra $5 to be able to defend ourselves properly?

Dr. MEROVKA. You got it.

Dr. KANIG. It is not just in case. There have been lawsuits because of patients who have gotten vaccines and may have had an adverse outcome as a result perhaps of that vaccination. It is known very, very rarely that vaccines can cause illness that occur idiosyncratically. Not because the vaccine is bad, but because we know 1 out of 10 million people who get a certain vaccine may get a bizarre autoimmune reaction to a vaccine and it will make them ill, and there have been tremendous product liability lawsuits that have resulted from that.

Mr. TOWNS. But I think when we have reached a point that a company indicates this is why we are doing it, I think it further points out that something needs to be done. That is what we are really saying.

Dr. KANIG. Absolutely.

Mr. TOWNS. And I assure you this is something we will take a very serious look at as we move forward with health care reform because reform can be either positive or negative. It is like prayer. You know, if somebody says they are going to pray for you, ask them what they are going to say.

So I feel this way about reform, it has to be good. So I am happy that you raised that point.

Let me ask one other question before we move forward. I guess I want to ask you, Dr. Merovka. You indicated a person can be involved in more than one HMO? In other words, if I wanted to participate in three HMOs, I can?

Dr. MEROVKA. Yes. Oh, the physician can, not the patient.

Mr. TOWNS. A better question. How do you select people to participate in HMOs?

Dr. MEROVKA. Well, in 1985, when they first came into Albuquerque, three of them came into Albuquerque. Every physician in the community was asked to participate. And because we were very unsophisticated and because we had a tremendous fear because of Lovelace's presence in the community, and this was very much fear driven, we all signed up, and then we started finding out what it was like to actually participate in the plans.

As a private practice physician, I can belong to as many HMOs as I care to, depending on how much I can stand in my fee discounting and the administration of the different plans. Actually, the physicians who are just HMO providers and who don't have any fee-for-service or whatever, most of them have left town because they have not been able to afford to practice medicine. Their fees were discounted to a point where they could no longer do that.

Those are usually the physicians, quite frankly, I might as well speak truthfully, who are marginal. They are ones that have not been able to necessarily do a practice because they are recognized as either not necessarily being caring enough or providing good

enough care that people wanted to continue to go to them. So you can belong to as many HMOs as you want to.

The problem HMOs in Albuquerque are having right now is that the bulk of the primary care physicians, internists, pediatricians, and family practitioners, are no longer able to accept any more new HMOs patients. We can no longer afford it. Things have been discounted to the point that our overhead is no longer being met, so a lot of HMOs are finding difficulty getting their new enrollees taken care of because their primary care panel is closed.

That has been a problem, so that they are trying to recruit new primary care physicians to take care of just their HMO patients, and that is being done.

In regard to the issue—I know this is an aside, but there are times when physicians in this community have withheld services from patients, have not referred them out appropriately, because they have been afraid of having an adverse financial impact on their practice, and that is a tremendous conflict of interest. It is an area that is not looked into, and it is an area that each individual physician has to have the integrity and the ethics to say, I don't care; I may not be looked at favorably by the HMO, but I am going to do what I think is right for the patient. And that still is the overwhelming philosophy in Albuquerque, which is very much HMO managed.

Mr. TOWNS. Let me just say that some areas in the country, I don't know whether you have the problem here, is that there are not enough primary care physicians.

Dr. MEROVKA. Absolutely.

Mr. TOWNS. I am not sure in terms of the situation here, but I know in terms of other parts of the country where that is a real problem, where people basically specialize. And that when it comes to locating primary care physicians, especially in the East, like New York City in particular, it is an area where you just do not have a lot of primary care doctors.

So I think we need to find a way to be able to change that. I am not sure how we do it, because 71 percent of the doctors in New York City specialize and only 29 percent probably would be qualified as primary care doctors. So we need to some way or another flip that based on what you are saying here in terms of the need.

You mentioned gatekeeper and all of that. I think in order to do it, we would have to bring about that flip, and I am not sure how we do that.

Dr. MEROVKA. I can tell you. I can give you an opinion.

Mr. TOWNS. OK, I would love to hear it.

Dr. MEROVKA. I have a pretty strong opinion about this because I am a family practice doctor. I am looked at—I am referred to as a generalist, as an old family practice doctor. I have a whole lot of terms that are used to describe me, but I look at myself and pediatricians and internists as being the backbone of this program. And the reason people don't go into this is because—one of the reasons is because the hours are grueling. I work 12 to 14 hours a day, and I do it because I have a real love for what I am doing, but at some point in time people burn out. That is one reason people don't go into it.

Somehow we have to have enough of us that that is not the way we have to practice. And I think that can happen just by increasing our numbers.

But the other part is that up until the HMOs, and this is another positive aspect of HMOs that I should have alluded to but I did not, up until 1985, primary care doctors in Albuquerque were still looked at as second class citizens. I graduated from the University of New Mexico's program, and it is a specialist driven program, and as a family practitioner I was still looked at as someone who was not quite as bright, not quite as able to take care of people.

And there is a lot of prejudice within our colleagues, within the medical community, and HMOs really changed that because now the specialists have to rely on us to refer patients to them. And that has been another underlying, very quiet area of discontent, in that the specialists are frightened that we are not going to refer to them any longer. They have seen their patient base in this city erode dramatically. So there is a sense of trust even among physicians that is not there any longer.

So having a little bit more—feeling that primary care is important and having that very slow conceptual change will be one of the main things that will drive people who are in education right now into primary care. Primary care is still at the very low rung of reimbursement. With the hours that I work, what I actually bring home—and I don't mind sharing this with you—is less than $80,000 a year, and that is a workweek that is very, very high, and that is simply because my reimbursement is held so stringently by the HMOs.

I am worth more than $80,000 a year. And I hate to say that I am all financially driven because, obviously, I am not. I am still working just as hard and still providing care. But you have to somehow figure out how much a primary care physician is worth in their salary, and we are still incredibly low, very, very low on the totem pole. Somebody coming out of cardiology can make anywhere from $300,000 to $350,000 to $500,000 a year, and I think that is too much, and I think society is going to say that is too much.

But you have to also, as a society, say primary care doctors, for the hours they work and the impact they can have on a person's life, not only on their physical life but also on their mental health, is dramatic. And so that has to be addressed also.

That is basically the three areas that can be changed. In California, they mandated that 50 percent of the people who go out of their programs, go out of their medical schools, have now got to go into primary care. How you will do that, I don't know. Because unless you change the milieu that primary care is involved in right now—and managed care is not looking at changing that. They are looking at tightening down the clamps even stronger. That is not going to be something that this country can look at.

The other thing which is very important on the primary care physician is that we really have to attract the best and the brightest of the medical students into primary care, because we can make an impact that prevents people from going to the specialist. It is like Dr. Kanig talked about, you can prevent a person going into dialysis if you are very good with their diabetic management. I can

prevent a patient going to a specialist if I am really well trained and I feel I can take care of hypertension, diabetes, difficult gynecological problems, even some basic orthopedic problems. There is a lot a primary care person can do that will save the specialist for what they need to be doing, which is the very complex patient. They should not be doing primary care.

Mr. TOWNS. Let me thank you very, very much, Dr. Merovka, Dr. Kanig, Mr. O'Brien, and Mr. McKernan.

If there are no other questions from the subcommittee—any other questions? Let me thank you very, very much for your testimony. You have been extremely helpful, and it also points out that in order to move forward and move forward effectively, we all have a lot of work to do.

Thank you for the information you have shared with us. Thank you very, very much.

Dr. MEROVKA. Thank you. We are a good group together.

Mr. TOWNS. The next panel we have, Howard Shaver, president of the New Mexico Hospital Association; Donald Naranjo, representing Mental Health Providers; Brett Davis, president of the New Mexico Association of Chiropractors; and also Michael Cohn, representing podiatric medicine.

Why don't we begin with you, Mr. Shaver.

STATEMENT OF HOWARD M. SHAVER, PRESIDENT, NEW MEXICO HOSPITAL ASSOCIATION

Mr. SHAVER. Thank you, Mr. Chairman. I am Howard Shaver, president of the New Mexico Hospital Association. I would like to welcome you to Albuquerque, NM, and to Representative Mica as well. Nice to have Steve back in town. He is back quite a bit.

Too bad you were not doing this last week so you could watch the hot air balloons. That is a real treat. I hope my presentation today has no relation to hot air balloons, but I will attempt to keep from that.

I have given your staff my prepared testimony. It changed significantly, partly because of the President's presentation on health reform and partly as I thought more and more about it, so that the testimony that was sent to you in the printed material has some similarities but a lot of changes in it.

Because, Mr. Chairman, and members of the subcommittee, you have heard already from some distinguished providers of services and one HMO representative how complex the issue of health care is and unlike many other issues, like Social Security and whatever, it has even more of a personal impact on each individual because all of us become consumers of care whether or not we make our living on the provider side.

We, as an association, have been an early proponent of major systemic health reform and have participated in the process here in New Mexico. Clearly, whatever comes out of Congress must assure universal access. All of the stakeholders and the biggest and most significant stakeholder being the public, must be considered in this process. Clearly, for the other players, whether they are providers of service, insurers, government, public health program officials or whatever, it is significant.

Another item that is very important is some flexibility in whatever plan is adopted. Congressman Schiff, of course, is very aware of the many uniquenesses of New Mexico, but I would like to point out some of these and you already, Chairman Towns, talked about the high rate of uninsured. But, in addition, we have a very diverse population. High Native American population, very rural, other than Albuquerque and a couple of other places. And that provides some real challenges to any health care program. So that we would urge there be flexibility given to individual States. So, clearly, the plan for New York State would be very different than that in New Mexico.

In my newly prepared testimony, there are a number of questions about health reform. This is not an exhaustive list but I think may be indicative of the kinds of things that must be considered.

What kind of linkages ought to exist among providers and what ought to be left to the uniqueness of the State or the substate level? What role will a purchasing cooperative play? Will it be primarily a broker or a consolidator of purchasers of care, or should it play a significant regulatory role?

One thing that is very important, as we look at universal access, is making very sure that the benefits promised and the appropriations or the dollars available for that match. We have gone through that in some other programs, where there have been significant benefits with inadequate revenues. If we go to universal health care, without appropriate funding, we will pull off another misrepresentation of what is being done.

I think a very important point that Mr. McKernan raised is what is the special role of medical education and other professional education in any reformed system. Because, clearly, giving a group of citizens a card but not doing anything about the infrastructure, and the educational program will not provide access. You have already talked about one part of that, the primary care provider issue—but there are a whole group of other health personnel who must be adequately trained, must have the appropriate support mechanism so that once they are trained, and they go to a rural area or an underserved area, that they have a system that supports their ability to provide services to the community. In New Mexico this relates more to its rural nature.

We very much believe that a top down, regulatory, micromanaged—and you heard from the physician representatives about micromanagement—system will not serve the needs of New Mexicans, whether they live in urban, rural, or what we call frontier areas, which have a population of less than 6 persons per 1,000. There are more cows and antelope per square mile in many parts of New Mexico than there are people.

Clearly, the issues—and we were pleased to hear from the President—of prevention, early intervention, and primary care must be considered.

To the topic of managed care. Albuquerque's premiums on the average, whether you are talking a managed care premium or a typical indemnity premium, is approximately 15 percent less than the national figure. Whereas, if you look at Albuquerque's cost of living, it is at the national median.

The HMOs and other factors have had a beneficial impact on this. New Mexicans are admitted to hospitals much less than their counterparts and remain in a hospital for much less time than their counterparts. Part of that has been helped with the HMO movement but also that has been traditional. We have been inventive in the uses of services like ambulatory surgery. We lead the Nation or are close to leading the Nation in that area, and that has been beneficial.

The challenge to each of us as providers of services is really changing how we provide service, and the traditional ways of providing service need to change. We need to make sure that we retain the appropriate items in our delivery system while making those changes.

And so let me add just a few points. Let me repeat the basic principles that we—and I use we as citizens, we as persons who are elected public officials, such as you are in Congress—have to really look at every one of the issues. It is very important that there be strong bipartisan debate about the President's plan and other plans, because this is so complex. We have found this to be the case here in New Mexico.

If this was an easy thing we would have solved it a long time ago. I don't believe change has been held back because of evil forces but because it is a very complex nature.

Items I would reiterate, universal coverage, flexibility, incentives for appropriate behavior, for both the provider and the consumer of care. An additional item I know you will hear about later, is small business subsidies. The issue of small business will be very important and is extremely important in this State.

Once again, I thank you very much for the opportunity to be here today and look forward to working with you directly or indirectly as you enter this important debate.

Mr. TOWNS. Thank you, very much, Mr. Shaver.

[The prepared statement of Mr. Shaver follows:]

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SUBCOMMITTEE ON HUMAN RESOURCES
AND
INTERGOVERNMENTAL RELATIONS
OF
U.S. HOUSE OF REPRESENTATIVES
GOVERNMENT OPERATIONS COMMITTEE HEARING

"MANAGED CARE: AN IN-DEPTH EXAMINATION"

HOWARD M. SHAVER, PRESIDENT
NEW MEXICO HOSPITAL ASSOCIATION

SUNDAY, SEPTEMBER 26, 1993
ALBUQUERQUE CONVENTION CENTER

Chairman Towns, Congressman Schiff, Congressman Mica and the Audience:

I am Howard Shaver, President, New Mexico Hospital Association. It is my pleasure to appear before your subcommittee today regarding the issue of managed care and the so called "Albuquerque Experience", as well as to comment on behalf of NMHA member organizations on managed care, its opportunities, its questions, and how President Clinton's health reform proposal and other proposals might affect New Mexico.

The New Mexico Hospital Association was an early proponent on major systemic health reform and has been a major participant in the reform process in New Mexico. The plan eventually adopted by Congress must assure universal access. The importance of this issue begs for vigorous debate by all stakeholders with the public being the most significant stakeholder. Flexibility for states, within an overall national plan is also essential to achieve a reform plan which meets the unique needs of New Mexico (28% uninsured, rural population, high Medicare and Medicaid, Native American population, Veterans and federal employees).

Questions About Health Reform

Some questions we believe are important for you in Congress to consider with any proposal which uses managed care or managed competition are:

1. What geographic areas must a plan be responsible for?
2. What linkages, and particular services, must be provided within certain distances of the home of the resident population?
3. What linkages among health care providers will be required, or should that be left to the unique circumstances of a state or a region of a state?
4. What role will the purchasing cooperatives play? Should the role be one of pooling purchasers or regulator as well?
5. How will, and should there be, spending caps placed at a regional, state or national level.
6. Will the financing be balanced with the benefits package?
7. What is the role of the local community in decision making?
8. What should be the role of medical and other health professional education in a reformed system including incentives for recruitment and retention of health personnel to rural and underserved areas?
9. Who should be responsible for infrastructure development?

The above are a few questions that need strong bipartisan debate in evaluating any proposal.

We believe that a top down regulatory micromanaged system will not serve the needs of New Mexicans, whether they live in urban, rural or frontier areas. Rather, we believe that allowing significant flexibility in how covered services are provided will be more beneficial in serving the needs of New Mexicans. Of course such services should include prevention, early intervention and primary care.

Managed Care In Albuquerque

As Congressman Schiff is aware, the Albuquerque area has long been an area of significant managed care activity. Now a significant percent of non-Medicare and Medicaid insured persons within the Albuquerque area receive care through four managed care networks. On average New Mexico's premium rates paid, compared with the nation are approximately 15 % less. The HMO movement has been driven both internal and external to New Mexico. In addition, some of the managed care programs are owned by health provider integrated delivery systems.

The significant influence of managed care programs in the greater Albuquerque area has changed institutional and non institutional health delivery and management including hospitals. No longer does a full hospital necessarily mean this is positive for either the system or the individual hospital. The incentives through both managed care and through the change to Diagnosis Related Groups (DRGs) for both Medicare and Medicaid have, in some cases, made it much more advantageous to provide services on an ambulatory or outpatient basis rather than an inpatient basis. If admission is necessary, it is only for the shortest time possible consistent with appropriate clinical care. Several managed care contracts now pay health care organizations on a capitation basis where both economically and clinically a hospital admission may mean the system did not function as well as possible; that an admission perhaps could have been avoided. Likewise, the combination of DRG payments and managed care have greatly increased the incentives for rapid provision of diagnostic and treatment services. This in turn, of course, has led to additional demand for home health services where appropriate. All are positive and provide greater incentives for more efficient care delivery.

Health reform has been, is, and will continue in New Mexico both in urban and rural areas, but will be accelerated through national or state legislation. Several proposals build upon managed care within an appropriate regulatory environment. We believe that the debate must assure appropriate accountability for accountable health plans with measurable quality outcomes. We, as a state and nation, must be extremely careful that we build upon the best of our system and change those parts that stand in the way of appropriate care for all.

Care Under Managed Competition

The managed care systems operation over the last several years in the Albuquerque area has been positive. Both the absolute amount of premium and the premium increases have been less than in other urban areas, where there is no managed care activity. A plan of universal coverage will allow small business and individuals to obtain coverage through purchasing cooperatives. Likewise, the principles contained in the major managed care proposals would lead to even more integrated networks that are in some ways similar to current health maintenance organizations, but which will provide a greater of a continuum of care and linkages throughout the state. This, of course, depends on the specifics of the plans' requirements for geographic coverage.

One difficulty of current managed care has been the requirement to discount, accept per diem payments or capitation payments on a portion of the hospital's services, coupled with continued pressure from Medicare and Medicaid and service to those unable to pay. Adequately financed universal coverage will address this problem. **If the resources made available and the benefits are not adequately matched, we could have universal coverage which would greatly raise consumers' expectations, but not provide adequate access to quality services.**

Non-Albuquerque Managed Care

You requested that we also comment on non-Albuquerque hospitals' attitude toward managed care. Frontier communities have seen little impact of managed care. Other more urban or semi-urban hospitals outside the Albuquerque area have been somewhat affected by managed care. Even without state or national health reform legislation, managed care will spread. Many hospitals are developing closer ties with their physicians and other public and private providers to allow to junction in a managed care environment and assure their communities are well served. Such action will be of great benefit to these communities.

Health Reform In Rural Areas

Several questions arise about the role of rural hospitals and other rural providers in a reformed delivery system. Any plan must consider the unique needs of rural communities and the role of rural providers including hospitals, community based primary care clinics and individual practitioners. In addition, we must carefully assure proper infrastructure and health personnel. Merely providing insurance cards to persons in underserved areas, will not assure adequate access. The plan must consider the availability of health personnel and both emergency and non-emergency transportation. Who should have the responsibility for this? There probably must be shared responsibility including separate and appropriate funding for medical and other health professional education, and incentives for practice by providers in underserved and rural areas. Incentives such as higher capitation rates in rural areas, may attract necessary providers to such areas. Likewise, the accountable health plans, through incentives or through eligibility may be encouraged to serve rural areas.

The principles we consider important are:

- Universal coverage.
- Flexibility
- Incentives for appropriate behavior
- Small business subsidies
- Match resources with benefits

Addressing such principles will go a long way toward meeting the unique needs of states like New Mexico and are essential to the development of a well functioning, acceptable health plan.

Again, thank you very much. Let me reemphasize a point I made earlier, NMHA and its members support major health system reform. We, as citizens, and you in Congress, must be sure we make appropriate changes to meet our communities' needs. Thorough and joint bipartisan debate will allow all issues to be considered and the best plan possible be developed. We look forward to working with you and others as you debate this important issue.

Chairman Towns, Congressman Schiff, and Congressman Mica, it's been my pleasure to be with you today. We thank you for your interest in this significant issue. Health reform is definitely the most significant domestic issue considered by Congress in this half century.

Mr. TOWNS. Dr. Naranjo.

STATEMENT OF DONALD R. NARANJO, Ph.D., EXECUTIVE DIRECTOR, RECREATIONAL HEALTH OCCUPATIONAL CENTER, INC., REPRESENTING MENTAL HEALTH PROVIDERS OF NEW MEXICO

Dr. NARANJO. Chairman Towns, subcommittee members, thank you for the opportunity to speak with you regarding the health maintenance organizations, specifically within the context of President Clinton's proposed national health care plan.

I am Dr. Donald Naranjo, the executive director for the Recreational Health and Occupational Center, RHOC, here in Albuquerque, NM. I also speak as a member of the New Mexico Mental Health Providers Association. My remarks, hopefully, will reflect the sentiments of my colleagues in the Mental Health Care Providers Association, but I will present those remarks within the context of my agency.

RHOC was initiated by members of the Albuquerque chapter of the National Alliance for the Mentally Ill. For those of you that are not familiar with NAMI, that is an organization of parents who have family members that are severely mentally ill and an extremely strong organization nationally with in excess of 100,000 members.

RHOC is New Mexico's largest freestanding psychosocial rehabilitation program. We serve adults afflicted with severe psychiatric disabilities. Consumers, our clients, of our program represent individuals who have a disabling mental illness that results in frequent episodes of psychiatric institutionalization, withdrawal from the community at large, incarceration, when services are not available, and many times suicide.

The subcommittee is encouraged to recognize that as a result of their illness, our consumers do not represent the average American when considering demographic characteristics such as education, socioeconomic status, employment or vocational status, political affiliation, et cetera. Although mental illness can strike in any family, we need to face the reality that depending on SSI, Medicaid, or SSDI benefits, Medicare, as their sole source of income relegates these individuals to the ranks of the poor.

Our consumers are those individuals who are typically victimized when left to fend for themselves on the streets of America without supportive services. They are the individuals who as a result of an illness, not a choice, tend to withdraw from society, experience discrimination through restricted access to health care, and blatant stigmatization from our society at large.

RHOC's consumers do not enjoy the same privileges afforded us here this morning. Why? Because of an illness that is not clearly understood, an illness that cannot be cured as of this date, and an illness that the majority of Americans do not understand and fear. Access to a comprehensive mental health service array is critical for those individuals with a severe psychiatric disability. A mental health service array must reflect a multidisciplinary approach to rehabilitation and recovery if we anticipate positive outcomes and cost-efficient interventions.

And I underscore cost-efficient interventions, not capitation.

Collaborative service systems, including psychosocial rehabilitation and psychiatry can produce positive outcomes. In light of my limited personal knowledge of details pertaining to mental health services within the proposed national health plan, I must limit the balance of my comments to sharing my personal concerns.

First, the Congress of the United States and the executive branch must work collaboratively to produce a bipartisan national health plan that serves to ensure that all citizens, regardless of their socioeconomic situation, place of residence or personal disability, have access to a full range of cost efficient and outcome-oriented health services. The role of health maintenance organizations in the provision of health services can be critical.

HMOs like the Lovelace health plan in New Mexico represent a pool of well qualified professionals postured to serve a large catchment area. My concern stems from the fact that HMOs don't presently serve the large majority of our consumers unless their families have the financial resources to secure such services. HMOs, in general—and I can certainly be wrong on this—do not provide the type and level of services needed by our consumers.

My invitation to speak before you outlines several areas of interest pertaining to HMOs and their impact on small businesses, rural communities, and senior citizens. I extend my apologies to this subcommittee. I do not consider myself an expert on HMOs. I do, however, manage a small business and provide mental health services to a small but significant subgroup of our national mosaic. I bring to you more questions than answers.

In drafting the final national health care plan, with that as your goal, I ask that you consider the following questions.

Will the lack of fiscal resources result in a long term, multitiered system of care where the economically or psychiatrically disadvantaged end up at the bottom of any priority list? Who will meet the needs of the severely mentally ill, who presently receive limited health care coverage through Medicaid or Medicare? What about the consumers without Medicaid or Medicare?

The national media indicate a national health care plan can be funded by reducing expenditures from Medicaid and Medicare services. If this is true, the funding scheme may, in fact, jeopardize the only health care coverage, although limited, presently available for our consumers. Will the system of care you help design ensure that services are cost effective and meet individual needs as opposed to meeting the needs of an agency's operating budget or their bottom line?

HMOs focus on reducing the utilization of services. Our consumers need their service array expanded for an indefinite period of time. How will this difference in management philosophy be reconciled?

I speak for my agency in saying that as a small business we will do our share, but will we be assured our consumers will be provided the coverage for the services they need?

In closing, I ask that in drafting a national health plan you consider the services provided, the mechanism established to monitor the proposed system of care and associated costs. Please keep in mind that everyone cannot be cured through a short-term regiment of medically based interventions.

The long-term mentally ill can benefit from an array of psychosocial rehabilitation and other support services in combination with medication and other psychiatric treatments. With this array, they can learn to live in their communities with a level of dignity that we all deserve. Thank you.

Mr. TOWNS. Thank you. Thank you very much.

[The prepared statement of Dr. Naranjo follows:]

THE COMMITTEE ON GOVERNMENT OPERATIONS

SUBCOMMITTEE ON HUMAN RESOURCES AND

INTERGOVERNMENTAL RELATIONS

CONGRESS OF THE UNITED STATES

REGARDING:
MANAGED CARE: AN IN-DEPTH LOOK AT HMO's

PRESENTED BY:

DONALD R. NARANJO, PH.D.
EXECUTIVE DIRECTOR
THE RECREATION, HEALTH, AND
OCCUPATIONAL CENTER, INC.
617 TRUMAN N.E.
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SEPTEMBER 26, 1993

THE COMMITTEE ON GOVERNMENT OPERATIONS
CONGRESS OF THE UNITED STATES

CHAIRMAN TOWNS, COMMITTEE MEMBERS, THANK YOU FOR THE OPPORTUNITY TO SPEAK WITH YOU REGARDING HEALTH MAINTENANCE ORGANIZATIONS WITHIN THE CONTEXT OF PRESIDENT CLINTON'S PROPOSED NATIONAL HEALTH CARE PLAN.

I AM DR. DONALD R. NARANJO, THE EXECUTIVE DIRECTOR FOR THE RECREATION, HEALTH, AND OCCUPATIONAL CENTER (RHOC) IN ALBUQUERQUE, NEW MEXICO. RHOC WAS INITIATED BY MEMBERS OF THE ALBUQUERQUE CHAPTER OF THE NATIONAL ALLIANCE FOR THE MENTALLY ILL. RHOC IS NEW MEXICO'S LARGEST FREESTANDING PSYCHOSOCIAL REHABILITATION PROGRAM. WE SERVE ADULTS AFFLICTED WITH SEVERE PSYCHIATRIC DISABILITIES. CONSUMERS, CLIENTS, OF OUR PROGRAM REPRESENT INDIVIDUALS WHO HAVE A DISABLING MENTAL ILLNESS THAT RESULTS IN FREQUENT EPISODES OF PSYCHIATRIC INSTITUTIONALIZATION, WITHDRAWAL FROM THE COMMUNITY-AT-LARGE, INCARCERATION WHEN SERVICES ARE NOT AVAILABLE, AND MANY TIMES SUICIDE.

THE COMMITTEE IS ENCOURAGED TO RECOGNIZE THAT, AS THE RESULT OF THEIR ILLNESS, OUR CONSUMERS DO NOT REPRESENT THE AVERAGE AMERICAN WHEN CONSIDERING DEMOGRAPHIC CHARACTERISTICS SUCH AS EDUCATION, SOCIO-ECONOMIC STATUS, EMPLOYMENT OR VOCATIONAL STATUS, POLITICAL AFFILIATION, ETC. ALTHOUGH MENTAL ILLNESS CAN STRIKE IN ANY FAMILY, WE NEED TO FACE THE REALITY THAT DEPENDING ON SSI OR SSDI BENEFITS AS THEIR SOLE SOURCE OF INCOME RELEGATES THESE INDIVIDUALS TO THE RANKS OF THE POOR. OUR CONSUMERS ARE THOSE INDIVIDUALS WHO ARE TYPICALLY VICTIMIZED WHEN LEFT TO FEND FOR THEMSELVES ON THE STREETS OF AMERICA WITHOUT SUPPORTIVE SERVICES. THEY ARE THE INDIVIDUALS WHO, AS A RESULT OF AN ILLNESS, NOT A CHOICE, TEND TO WITHDRAW FROM SOCIETY, EXPERIENCE DISCRIMINATION THROUGH RESTRICTED ACCESS TO HEALTH CARE AND BLATANT STIGMATIZATION FROM OUR SOCIETY AT LARGE. RHOC'S CONSUMERS DO NOT ENJOY THE SAME PRIVILEGES AFFORDED US HERE THIS MORNING -- WHY? BECAUSE OF AN ILLNESS THAT IS NOT CLEARLY UNDERSTOOD, AN ILLNESS THAT CANNOT BE CURED AS OF THIS DATE, AND AN ILLNESS THAT THE MAJORITY OF AMERICANS DO NOT UNDERSTAND AND FEAR.

ACCESS TO A COMPREHENSIVE MENTAL HEALTH SERVICE ARRAY IS CRITICAL FOR THOSE INDIVIDUALS WITH A SEVERE PSYCHIATRIC DISABILITY. A MENTAL HEALTH SERVICE ARRAY MUST REFLECT A MULTI-DISCIPLINARY APPROACH TO REHABILITATION AND RECOVERY IF WE ANTICIPATE POSITIVE OUTCOMES AND COST EFFICIENT INTERVENTIONS. COLLABORATIVE SERVICES SYSTEMS INCLUDING PSYCHOSOCIAL REHABILITATION AND PSYCHIATRY CAN PRODUCE POSITIVE OUTCOMES.

IN LIGHT OF MY LIMITED PERSONAL KNOWLEDGE OF DETAILS PERTAINING TO MENTAL HEALTH SERVICES WITHIN THE PROPOSED NATIONAL HEALTH PLAN I MUST LIMIT THE BALANCE OF MY COMMENTS TO SHARING MY PERSONAL CONCERNS. FIRST, THE CONGRESS OF THE UNITED STATES AND THE EXECUTIVE BRANCH MUST WORK COLLABORATIVELY TO PRODUCE A BIPARTISAN NATIONAL HEALTH PLAN THAT SERVES TO ENSURE THAT ALL CITIZENS, REGARDLESS OF THEIR SOCIO-ECONOMIC SITUATION, PLACE OF RESIDENCE, OR PERSONAL DISABILITY, HAVE ACCESS TO A FULL RANGE OF COST EFFICIENT AND OUTCOME ORIENTED HEALTH SERVICES.

THE ROLE OF HEALTH MAINTENANCE ORGANIZATIONS IN THE PROVISION OF HEALTH SERVICES CAN BE CRITICAL. HMO'S, LIKE THE LOVELACE HEALTH PLAN IN NEW MEXICO, REPRESENT A POOL OF WELL QUALIFIED PROFESSIONALS POSTURED TO SERVE A LARGE CATCHMENT AREA. MY CONCERN STEMS FROM THE FACT THAT HMO'S DO NOT PRESENTLY SERVE THE LARGE MAJORITY OF OUR CONSUMERS, UNLESS THEIR FAMILIES HAVE THE FINANCIAL RESOURCES TO SECURE SUCH SERVICES. HMO'S IN GENERAL DO NOT PROVIDE THE TYPE AND LEVEL OF SERVICES NEEDED BY OUR CONSUMERS.

MY INVITATION TO SPEAK BEFORE YOU OUTLINED SEVERAL AREAS OF INTEREST PERTAINING TO HMO'S, THEIR IMPACT ON SMALL BUSINESSES, RURAL COMMUNITIES, AND SENIOR CITIZENS. I EXTEND MY APOLOGIES TO THIS COMMITTEE. I DO NOT CONSIDER MYSELF AN EXPERT ON HMO'S. I DO HOWEVER MANAGE A SMALL BUSINESS AND PROVIDE MENTAL HEALTH SERVICES TO A SMALL BUT SIGNIFICANT SUBGROUP OF OUR NATIONAL MOSAIC. I BRING TO YOU MORE QUESTIONS THAN ANSWERS. I HOPE THAT EACH MEMBER OF THIS COMMITTEE TAKES AN ACTIVE ROLE IN DRAFTING THE FINAL NATIONAL HEALTH CARE PLAN. WITH THAT AS YOUR GOAL I ASK THAT YOU CONSIDER THE FOLLOWING QUESTIONS:

1. WILL THE LACK OF FISCAL RESOURCES RESULT IN A LONG-TERM, MULTI-TIERED SYSTEM OF CARE WHERE THE ECONOMICALLY OR

PSYCHIATRICALLY DISADVANTAGED END UP AT THE BOTTOM OF ANY PRIORITY LIST?

2. WHO WILL MEET THE NEEDS OF THE SEVERELY MENTALLY ILL, WHO PRESENTLY RECEIVE LIMITED HEALTH CARE COVERAGE THROUGH MEDICAID OR MEDICARE? WHAT ABOUT THE CONSUMERS WITHOUT MEDICAID OR MEDICARE?

3. THE NATIONAL MEDIA INDICATE THAT A NATIONAL HEALTH CARE PLAN CAN BE FUNDED BY REDUCING EXPENDITURES FOR MEDICAID AND MEDICARE SERVICES. IF THIS IS TRUE, THE FUNDING SCHEME MAY IN FACT JEOPARDIZE THE ONLY HEALTH COVERAGE, ALTHOUGH LIMITED, PRESENTLY AVAILABLE FOR OUR CONSUMERS.

4. WILL THE SYSTEM OF CARE YOU HELP DESIGN ENSURE THAT SERVICES ARE COST EFFECTIVE AND MEET INDIVIDUAL NEEDS AS OPPOSED TO MEETING THE NEEDS OF AN AGENCY'S OPERATING BUDGET? HMO'S FOCUS ON REDUCING THE UTILIZATION OF SERVICES -- OUR CONSUMERS NEED THEIR SERVICE ARRAY EXPANDED FOR AN INDEFINITE PERIOD OF TIME. HOW WILL THIS DIFFERENCE IN MANAGEMENT PHILOSOPHY BE RECONCILED?

5. I SPEAK FOR MY AGENCY IN SAYING THAT AS A SMALL BUSINESS WE WILL DO OUR SHARE. BUT WILL WE BE ASSURED THAT OUR CONSUMERS WILL BE PROVIDED COVERAGE FOR THE SERVICES THEY NEED?

IN CLOSING I ASK THAT IN DRAFTING A NATIONAL HEALTH PLAN YOU CONSIDER THE SERVICES PROVIDED, THE MECHANISM ESTABLISHED TO MONITOR THE PROPOSED SYSTEM OF CARE, AND ASSOCIATED COSTS. PLEASE KEEP IN MIND THAT EVERYONE CAN NOT BE CURED THROUGH A SHORT-TERM REGIMEN OF MEDICALLY-BASED INTERVENTIONS. THE LONG-TERM MENTALLY ILL CAN BENEFIT FROM AN ARRAY OF PSYCHOSOCIAL REHABILITATION AND OTHER SUPPORT SERVICES IN COMBINATION WITH MEDICATION AND OTHER PSYCHIATRIC TREATMENTS. WITH THIS ARRAY, THEY CAN LEARN TO LIVE IN THEIR COMMUNITIES WITH A LEVEL OF DIGNITY THAT WE ALL DESERVE.

Mr. TOWNS. Dr. Davis.

STATEMENT OF B. BRETT DAVIS, CHIROPRACTOR, PRESIDENT, NEW MEXICO CHIROPRACTIC ASSOCIATION

Dr. DAVIS. I want to thank your subcommittee, Chairman Towns, and Mr. Schiff and Mr. Mica, for inviting me to speak today.

I am currently the president of the New Mexico Chiropractic Association. I will have some short remarks.

In the State of New Mexico, there are 329 licensed chiropractic physicians. Approximately 111 of those 329 practice in Albuquerque. A total of 15 chiropractors, or about 14 percent, participate in the delivery of health care as providers for an HMO.

Those few doctors who are allowed to participate in a health maintenance organization are pleased. They are receiving by referral approximately three new patients per week who are given a prescription of two to six treatments. Reimbursement for their service is $30 to $35 per office visit. The patient is responsible for 50 percent and the plan pays the other 50 percent.

This represents $17 to the provider for each visit by the patient. This equates to 150 patients per year per doctor. At four visits per patient, the yearly reimbursement is $18,000 per doctor, or roughly $120 per patient.

My question is how can 86 percent of Albuquerque chiropractors excluded from the plan be pleased and why should the 14 percent who are included feel adequately compensated with a $35 reimbursement? Chiropractors, through Albuquerque HMOs, are not being adequately utilized in our opinion.

A conservative estimate of 250,000 chiropractic visits are made each year in Albuquerque; 9,000 of these are referred by HMOs. This represents about 4 percent of the office visits for chiropractic treatments, and we feel this may be a high percentage.

Nationally, chiropractic physicians are utilized by 7.5 percent of the population, with a total health care expenditure of approximately $2 billion. Actually, it is a little more, it is about $2.3 billion of total health care expenditures. This is a statistically insignificant percentage of dollars being spent within the current system for chiropractic care.

A survey of data bases of health insurance companies reveal that chiropractic users tend to have substantially lower health costs. The British Journal of Medicine constructed a 10-year retrospective study on the efficacy and long-term effects of chiropractic treatment and basically their report indicates that the potential economic resource and policy implications of the results are extensive.

There was a 50-year review of clinical trials published in professional literature between 1930 and 1981, which examined—it was examined by the Department of Defense. This report was favorable to chiropractic in several different areas.

I will dispense with reading the rest of this, but basically a large Florida-based HMO called AV–MED utilized chiropractic services. In Florida 100 consecutive low-back and neck pain patients were referred to a local chiropractor; 12 of those patients were medically diagnosed as needing surgery. None eventually needed to have surgery. At 6 months followup, 86 percent had used no further chiropractic or medical services, and in the HMO, AV–MED considered

it had a cost savings of approximately $225,000 just based on the medical and surgical costs, less the cost of chiropractic. And based on that, AV–MED decided to—it changed its policy to require all patients receive chiropractic assessment before referral to the hospital for back and neck pain.

A study conducted by the RAND Corp. marks the first time that representatives of the medical community have gone on record stating that chiropractic is an appropriate treatment for certain low-back pain conditions. Basically, current research about the efficacy and cost effectiveness of chiropractic care concludes that the chiropractic profession has great potential to decrease the pain and suffering of Americans and reduce health care costs.

Given the historical polarity of the medical community and the chiropractic profession, we view the managed care model with cynicism. We believe a gatekeeper system that is ill-informed or not open-minded or is driven by inherent conflicts of interests will not make referrals based on scientific information, but will rather make referrals based on financial incentive or historical bias. This type of gatekeeper system negates an important aspect of the managed competition model.

Our position is competition at all levels must be preserved not just between competing hospitals or HMOs but between providers. We feel that there should be a bifurcation of the gatekeeper system. Basically, under that proposed system, patients that are suffering from conditions related to neuromusculoskeletal injuries or pain would be evaluated by a chiropractic physician gatekeeper, and we believe such conservative, noninvasive expert evaluation in and by itself could save millions of health care dollars.

Musculoskeletal complaints are the second ranking reason for a patient to seek out a health care provider. Upper respiratory complaints are the leading cause. As the court made clear in the Wilk versus the AMA case, the medical gatekeeper is basically untrained to either diagnose or treat problems with the dynamics of the neuromusculoskeletal system, including the spinal column. And the chiropractor, on the other hand, is trained to diagnose not only neuromusculoskeletal problems but also diagnose cases requiring further medical review.

In conclusion, the chiropractic profession believes it has paid its dues. We believe we are uniquely American, having been founded in Davenport, IA in 1895. We have developed over the past 100 years into the third largest health care profession in America next to medicine and dentistry. We have 45,000 licensed physicians in all 50 States. There are 17 chiropractic colleges in America and also colleges in Canada, Europe, and Asia.

We have survived an illegal boycott which targeted the chiropractic profession for complete containment, isolation, and elimination. This sad chapter in the chiropractic profession's history cannot fully be put behind us until we have some assurances that health care reform will not continue to support the isolation of the past.

We believe medical gatekeepers will only continue the policy of status quo, which keeps chiropractic patients from chiropractic physicians. I am looking to this body to help break the status quo

and create true competition in the health care marketplace, and my profession is ready, willing and able to help you do so.

Mr. TOWNS. Thank you very much, Dr. Davis, for your testimony.

[The prepared statement of Dr. Davis follows:]

TESTIMONY OF THE NEW MEXICO CHIROPRACTIC ASSOCIATION BEFORE THE HOUSE COMMITTEE ON GOVERNMENT OPERATIONS MANAGED CARE: AN IN-DEPTH EXAMINATION PRESENTED BY B. BRETT DAVIS, D.C. N.M.C.A PRESIDENT

In the State of New Mexico there are 329 licensed chiropractic physicians. Approximately 111 of those 329 practice in Albuquerque. A total of fifteen chiropractors, or 14%, participate in the delivery of health care as providers for an HMO.

Those few doctors who are allowed to participate in a Health Maintenance Organization are pleased. They are receiving, by referral, approximately three new patients per week who are given a prescription of 2-6 treatments. Reimbursement for the service is $30-$35 per office visit. The patient is responsible for 50% and the plan pays the other 50%. This represents $17 to the provider for each visit by the patient. This equates to 150 patients per year per doctor. At four visits per patient, the yearly reimbursement is $18,000 per doctor, or roughly $120 per patient.

How can 86% of Albuquerque chiropractors, excluded from the plan, be pleased; and why should the 14% included in the plan feel adequately compensated with a $35 reimbursement. Chiropractic, through Albuquerque HMOs, is not being adequately utilized.

A conservative estimate of 250,000 chiropractic visits is made each year in Albuquerque; 9,000 of these are referred by HMOs. This is 4% of office visits for chiropractic treatment (and this percentage is probably high).

Nationally, chiropractic physicians are utilized by 7.5% of the population with a total health care expenditure of approximately 2 billion dollars. This represents less than .002% dollars spent on health care. This is a statistically insignificant percentage of dollars being spent within the current system for chiropractic care.[1]

A survey of data bases of health insurance companies revealed that chiropractic users tend to have substantially lower total health costs.[2]

The British Journal of Medicine conducted a ten year retrospective study on the efficiency and long term effects of chiropractic treatment and hospital outpatient treatment for low back pain. The study concluded that chiropractic confers worthwhile, long term benefit in comparison to hospital outpatient management. The study also reports, "The potential economic, resource, and policy implications of our results are extensive."[3]

A fifty year review of clinical trials published in professional literature between 1930 and 1981 were examined in a report by the Department of Defense in 1986. In this report, it was found that manual therapy was superior to placebos, the duration of treatment was shorter for those groups receiving manipulative therapy and that patients are satisfied with the outcome of treatments.[4]

A large Florida based HMO called AV-MED referred one hundred consecutive patients with the chief complaint of persistent low back or neck pain to a local chiropractic physician for evaluation and treatment; a) These patients had already been seen by 1.6 medical doctors on average b) 2% had already been hospitalized and c) 12% had been confirmed medically as requiring surgery. The chiropractic care consisted of spinal manipulation supplemented with physiotherapy modalities, remedial exercises, and advise. The average number of visits per patient was 12.1 at an average total cost of $326.76. No patient, including the 12 medically diagnosed as needing surgery, required surgical intervention. At six months follow up, 86% had used no further chiropractic or medical services. AV-MED considered it had a cost savings of approximately $225,000 (medical and surgical costs, less the cost of chiropractic care) on the confirmed surgical cases alone. This was the estimated costs savings in 1983 dollars. Based on this trial study, AV-MED changed its policy to require all patients to receive chiropractic assessment before referral to the hospital for back and neck pain.[5]

A study conducted by the RAND corporation marks the first time that representatives of the medical community have gone on record stating that chiropractic is an appropriate treatment for certain low back pain conditions.[6]

Current research about the efficacy and cost effectiveness of chiropractic care concludes that the chiropractic profession has great potential to decrease the pain and suffering of Americans and reduce health care costs.

Given the historical polarity of the medical community and the chiropractic profession, we view the managed competition model with cynicism. We believe that a gatekeeper system that is ill informed or not open minded or is driven by inherent conflicts of interest will not make referrals based on scientific information but will rather make referrals based on financial incentive or historical bias. This type of gatekeeper system negates an important aspect of the managed competition model. Our position is that competition at all levels must be preserved, not just between competing hospitals or HMO's, but between providers. This can be accomplished by having a bifurcation of the gatekeeper system. Under this proposed system every patient suffering from a condition related to neuromusculoskeletal (hereinafter referred to as NMS) injury or pain would be evaluated by the chiropractic physician

gatekeeper. We believe that such conservative, non invasive expert evaluation in and by itself could save millions of health care dollars.

Musculoskeletal complaints are the second ranking reason for a patient to seek out a health care provider. Upper respiratory complaints are the leading cause.

As the court made clear in Wilk v. AMA, 895 F2d. 352 (cert. den. 110 S.Ct.2621, June 11, 1990), the medical gatekeeper is untrained to either diagnose or treat problems with the dynamics of the NMS system, including the spinal column. The chiropractor, on the other hand, is trained to diagnose not only NMS problems, but also differentially diagnose cases requiring medical review.

The chiropractic profession is adamant about the need to preserve the patient's freedom to choose a chiropractic physician. If the current system resists reform in regard to allowing for freedom of choice of non M.D. providers, then the system will continue to preserve elements of the monopoly that the Wilk, infra, decision was meant to remedy.

In conclusion, the chiropractic profession believes it has paid its dues. We are uniquely American. We were founded in Davenport, Iowa in 1895 and have developed over the past 100 years into the third largest health care profession in America next to medicine and dentistry. We have 45,000 licensed physicians in all 50 states. There are 17 chiropractic colleges in America and also colleges in Canada, Europe, and Asia. We have survived an illegal boycott which targeted the chiropractic profession for complete "containment, isolation, and elimination". This sad chapter in the chiropractic profession's history cannot be fully put behind us until we have some assurances that health care reform will not continue to support the isolation of the past. We believe that medical gatekeepers will only continue the policy of status quo which keeps chiropractic patients from chiropractic physicians.

I am looking to this body to help break the status quo and create true competition in the health care market place. The chiropractic profession is ready, willing and able to assist in the process of health care reform.

ENDNOTES

1. Journal of Family Practice, Vol. 35, No. 5, Nov. 1992

2. Stano, M., Ehrhart, J., et al. "The Growing Role of Chiropractic in Health Care Delivery," Journal of American Health Policy, November/December 1992, Volume 2, Number 6, pages 39-45

3. British Medical Journal, 2 June 1990, Vol. 300, Number 67137

4. MacDonald, M. J., Morton, L. Chiropractic Evaluation Study Task III Report of the Relevant Literature. MRI Project No. 8533-D, For Department of Defense, OCHAMPUS, Aurora, Colo. 24 January 1986.

5. Silverman M. (1983), "Study of the First 100 patients Referred to the Silverman Chiropractic Center by AV-MED", unpublished personal communication (1987).

6. Shekke, P. G., Adams, A., et al The Appointment of Spinal Manipulation for Lower-Back Pain. RAND Corporation, Santa Monica, Ca. 1992.

Mr. TOWNS. Dr. Cohn.

STATEMENT OF R. MICHAEL COHN, DPM, PODIATRIC PHYSICIAN, ALBUQUERQUE, NM

Dr. COHN. Thank you very much. I have just decided I will forego reading my testimony because I am going to assume——

Mr. TOWNS. Let me say the entire statement will be included in the record, so feel free.

Mr. SCHIFF. It has already been said.

Dr. COHN. That is what I believed, so I thought I would kind of tell you what is in it, in my own words, and that is I am a privately practicing physician, podiatric physician, in Albuquerque, and have been for 13 years. And, first of all, I don't represent anyone but myself. I was president of the Podiatry Association several years ago but I don't hold any elected position at this time.

I think I am in a little bit of a unique position because everyone else has some affiliations that they have to go back to and answer to and I don't have that kind of affiliation. I am associated with the Albuquerque Family Health Centers, which provides medical care in many different primary care fields, and I am pleased to say podiatry as well, to the low income and indigent people in Burnalillo County, where Albuquerque is situated.

I am proud of that affiliation because I was getting the award for medical volunteer of the year and they got tired of giving me that so they said they would pay me something as opposed to—I always say instead of working for nothing I held out for next to nothing, and I do that 1 day a week. And it strikes me as interesting that the other doctors will say that doing services for Medicaid patients is doing charity.

It is to some extent because there is a certain—you make very little money doing work for Medicaid patients, but you make a lot less money when you treat people who have no money whatsoever to pay you.

And I know doctors all over town, most doctors do that sort of work, and I don't know if a lot of other professions do that during their day-to-day chores, but physicians do that.

Regarding HMOs, my experience has been somewhat similar to the chiropractic experience in that I find there are three kinds of HMOs. There is an HMO in town that has a couple of podiatrists on staff, two or three, and they have about a third of the city, and they have about 15 percent of the podiatrists on their staff. The lines are long over there. And I guess charity work or work on people who are not in their HMOs just is not their business.

I am not saying I know that to be a fact, but I think they see the people who are in their HMO—and anybody else who has any kind of insurance can come and see them as well—but if you don't have insurance or their HMO, I don't think they treat you there. That is kind of a unique position, I think. This is my opinion strictly.

There is another type of HMO that I have encountered and that is the one who just is not taking podiatrists. They have a podiatrist and they don't want any more. The law says they have to have a podiatrist so they have one, and that is, I think, just going by the letter of the law and not the spirit. And it is very hard to see a

podiatrist within that system, and those people come to me and say, well, they told me it will be a month before I can get this infected ingrown nail taken care of, but can you get me some antibiotics, I will pay you for a visit for right now, and I nurse them along until they can get back into their HMO system.

And that is very inefficient in my mind and not right for the public and it is not right for the profession of podiatry as well. Doesn't service the public or podiatry. It serves the profit motive of the HMO.

The third kind is an HMO that took everybody, anybody who wanted to be a podiatrist in that HMO could go in. And that was nice at first, because they paid us like they paid most other doctors, about the same rate. A little less than the going rate at that time but they sent a high volume of people. Then they saw podiatry was needed and they realized they were putting out way too many funds in podiatry, I believe.

I didn't speak to them personally, but every year they said they had to pay us less and less. We were getting paid 70 percent, and then the next time the contract came out it was 60, 50, 40. And Medicaid was paying better than 40. So when they hit that level, I said just said, well, I can't work for them any more either, I guess. It was too difficult to try to see the masses of people that were sent through for that low a fee.

I am not affiliated with any HMOs, as you can see. Those are the three kinds of HMOs I have encountered in reference to podiatry in New Mexico.

In regard to the gatekeeping system, my experience has been that a lot of internists, primary care physicians, will tell you they were not trained very well in taking care of feet. Taking care of foot and ankle problems was just not something that was stressed even in primary care training, in their residencies or in their medical schools, and a lot of doctors simply do physicals with a person's shoes on. They will tell you that when it comes down to treating feet, they are not really very expert in this area and they would just prefer to send a person to a podiatrist, and I appreciate that very much.

I think that when you have a gatekeeper who is trying to treat foot problems, because he has had a very limited amount of experience in treating a foot problem and tries to take care of a podiatric complaint and then sends it on to a podiatrist, it is a waste. It is a bureaucratic boondoggle. It just keeps the person from getting the care they need for a while.

Sometimes they are met with success, I am sure, and many times they just give up and refer to a podiatrist. And the financial incentive to not refer is something that I think has to be eliminated from the HMO system because it is simply a waste.

There is a model in an HMO here, I understand, if I can compare optometry and ophthalmology to podiatry and orthopedics. There is an HMO that lets people with eye problems go to an optometrist first and the optometrist determines if they are going to need eye surgery and refers them to an ophthalmologist. I think having foot and ankle problems go to an orthopedist who decides whether he needs a podiatry consult is a waste also.

I think if there is an intake position that it needs to be the podiatric physician who serves as the person who decides whether this is within his scope of practice or perhaps refers occasionally to an orthopedist if it needs additional expertise.

I think that pretty well says what is in my paper and I thank you very much for your time.

[The prepared statement of Dr. Cohn follows:]

DR. MICHAEL COHN, P.C.

Statement
of

R. Michael Cohn,DPM,MS

Before the

Subcommittee on Human Resources
and
Intergovernmental Relations

Committee on Government Operations

United States House of Representatives

on:

Managed Care: An In-Depth Look at HMOs

September 26, 1993

8008 MENAUL BLVD., N.E. ALBUQUERQUE, NEW MEXICO 87110 TELEPHONE 293-6500

Mr. Chairman, members of the Subcommittee:

I am Dr. Michael Cohn, a podiatric physician in Albuquerque, New Mexico, in my thirteenth year of private practice. Thank you very much for inviting me to testify before this body on the subject of "Managed Care: An In-Depth Look at HMOs." Although I was president of the New Mexico Podiatric Medical Association for the years 1989 and 1990, I do not currently hold any elected office. I am affiliated with the Albuquerque Family Health Centers, where I give podiatric care to indigent and low income people one day each week. At first I was hesitant because I did not have the authority of representing a large group, like the other people who were invited here today. But perhaps I can be of assistance for just that reason: I am not accountable to any employer or to any other group or interest other than my own conscience.

The focus of our concern here today is not whether podiatry should be included in a national health care plan, but rather how it should be included. Also, I understand that our debate is not regarding the best overall type of plan, such as single payor vs. managed competition, but rather focusing just on HMOs and our role as podiatrists within them. I strongly suggest that the HMO type of health care plan is inherently unfair to both the providers and to the public that they care for, and that freedom to choose ones doctor is only an illusion within HMOs. HMOs are also not desirable from an economic perspective. Medicare, which could be seen as a single payor model, has an administrative cost of 2.3% and HMOs average a 20% administrative cost here in New Mexico. (source: NM Insurance Department) I believe the main differences are that Medicare does not advertise and is not for profit.

As you know, Albuquerque has a large percentage of its population covered by HMO plans. The impact of these plans on every private practitioner, in podiatry and all other fields, has been enormous. By taking a large segment of society and putting it out of the reach of podiatrists not admitted on HMO panels, the public's freedom of choice as well as the doctors' is hindered. New Mexico has the largest percentage of uninsured population as well, 25%, so this further narrows down the population served in most private offices. (source: NM Hospital Association)

The HMOs that I have experienced seem to be classifiable into three groups:

1. They have a small number of podiatrists who are full time employees.
2. They have one or two podiatrists who fill their need to give podiatric care in a very minimal way.
3. They let a large number of podiatrists enter the program and then pay less and less each year until most are forced to drop out.

Let us consider each group separately:

1. The first HMO has about 15% of the city's podiatrists serving about a third of the city's population. The lines are long. This serves neither the public nor the profession well.
2. The second method fills the letter of the law and avoids the spirit. By having one or two podiatrists, they use the tried and true policy of private clubs that admit one minority member.
3. Under this plan, the HMO pays less until they have the number of podiatrists they want, as the podiatrists leave of their own free will. They set their fee level by the minimal service for which their customers will settle. This particular HMO had large profits.

I won't defend or choose between any of these plans. I have chosen so far to not provide services for any of these HMOs, having not been accepted at the HMOs in the first and second categories, and having dropped out of the third when their payment schedule dropped well below that of Medicaid.

The question becomes: What kind of plan would serve the public and the profession well? I assume what applies to podiatry also is pertinent to several other fields within medicine. It is clear that I am not a proponent of HMO type systems, but rather single payer. But if HMOs are destined to be the main system, I suggest that the governing regulations require that all physicians who apply to be plan providers be given admission unless they do not meet basic standards that ensure the public safety. This would give some freedom of choice for the providers if not the public. Only single payer gives true freedom of choice to the public in my opinion.

I believe that the competitive aspect within managed care should be to administer the plans with the most efficiency. In the current systems, the management pays itself as much as possible, and pays the providers as little as possible. Large parts of the budgets go toward advertising and competing for business. So instead of working at providing a better service, they strive to improve their image of appearing to provide a better service, while shifting money away from paying for services for the beneficiaries. In my humble opinion, this is not the best way of caring for the American public.

I believe that the profession of podiatry is in the best position for giving the foot care that a universal plan will encompass. Foot health services should be mandated within all HMOs and all other managed care entities, such as PPOs and IPAs. Since experience teaches us that simply mandating podiatric care does not ensure that sufficient numbers of providers or service will be included, these issues should be addressed, either by a National Health Board, or by Congress itself. I would lean toward the latter. Standards should be established that are very specific so that HMO managers can not keep the public from receiving the services that are a necessity to good health.

On the subject of gatekeepers: this system only puts one more unnecessary layer of bureaucracy between the patient and the proper physician. The gatekeeping system also puts the gatekeeper in a position of increased malpractice liability if the specialist is not consulted due to financial pressures on the primary physician not to refer. If a gatekeeper model is part of the HMO system that is unchangeable,I believe that podiatrists are the best professionals to serve as gate keepers for foot and ankle services. If a system is put in place where all patients have to enter the system through primary care doctors, either let podiatrists be classified as primary care providers of foot care, or have the system set up so that all foot problems are sent from the intake point to a plan podiatrist. Just as Medicare has standards that determine which services will be covered, similar standards could be applied universally and allow podiatrists to work within prescribed standards of care. These standards, which should be drafted by podiatrists, could be established by a board that oversees all managed care groups, and enforced by periodic reviews or audits of providers. Most primary care doctors do not have the knowledge or desire to provide foot care services. Orthopedists can spend their time better elsewhere. Podiatrists can refer to orthopedists or other specialists when the service needed is beyond their scope of practice, rather than orthopedists referring to podiatrists when the service needed is less than would be efficient for them to provide.

To summarize, I would recommend:

1. Podiatry should be a mandated service in all managed care groups.
2. Require open panels of providers so that all qualified podiatrists can participate.
3. Standardize the criteria for podiatric services to be given and let podiatrists work within those standards, which should be modified periodically.
4. Let podiatry serve as the entry point for patients with foot and ankle problems.

Furthermore:

1. Limit and regulate the profits made by HMO management, in concurrence with limiting fees paid to doctors if necessary.

2. Limit the amounts that HMOs can spend on advertising, if legally possible, or change the law.

3. Eliminate ERISA, which provides for a special class of patients that does not have to live within the regulations that are binding on the rest of us.

Writing a plan that will be universally applied, fair to both the public and the providers, that gives a basic benefit to every citizen and an even playing field to all providers, is a huge task and I do not envy you in that job.

Thank you for giving me this opportunity. I know that you would like to have the time to listen to all concerned, and I am honored that you chose me.

Mr. TOWNS. Thank you very, very much for your testimony, and we thank all of you for your testimony.

At this time I would yield to Congressman Schiff.

Mr. SCHIFF. Once again, Mr. Chairman, I want to congratulate all the witnesses on very fine testimony here together. I just have a couple of questions.

Mr. Shaver, on behalf of the hospitals, we had testimony from a representative of the University of New Mexico Hospital who talked about the fact that in negotiating with HMOs certain extra additions to the premium were asked for to help cover the uninsured who were treated and so forth were not forthcoming from HMOs. It was very tough negotiation in that regard.

Speaking for the other hospitals, do you find that to be the case also? And, if so, is there any criticism of that? Do you feel they have some obligation to pay extra in a cost-shifting manner?

Mr. SHAVER. Congressman Schiff, every hospital does provide a significant amount of indigent care, and in my written testimony I refer to the current problems of a hospital who does not own an HMO, of contracting with an HMO, with the added burdens of Medicare underpayments, Medicaid underpayments, and indigent care.

Our hope is that, as my testimony indicated, with universal coverage, we won't have indigent patients anymore. And if the benefits and the resources available are appropriate, that problem will be eliminated so that would go away.

Mr. McKernan also discussed the issue of medical education. There clearly has to be an appropriate funding mechanism, and I believe it ought to be outside of the payment system, then that would allow the providers of services to be competitive, whether they are a hospital or another provider, in negotiating with accountable health plans or whatever.

So it has been a problem. With universal coverage, that problem would go away, especially if there is also—universal coverage tied with appropriate funding for professional education costs, which are different, and the Medicare and Medicaid program do somewhat recognize this in their payment systems. A universal health care national plan has to recognize that as well.

Mr. SCHIFF. Let me just say collectively to the other three witnesses that I think that in viewing managed care, in any plan that we come up with, I think the needed aspects of all other health care providers needs to be properly taken into consideration. I am speaking only for myself as an individual.

To Dr. Naranjo, very close individuals in my family have had a history of mental illness and I understand the challenge of treating such patients, because they look healthy and normal on the outside and people kind of wonder what is wrong. If they were missing a leg, you would not wonder what is wrong. It is harder to deal with.

Dr. Cohn, as you well know, I have seen podiatrists personally. Have not needed to lately, but certainly have in the past. And I have to say that I personally have not seen a chiropractor, but I know many, many people who have in the community certainly.

And the point is all the same whether I am talking about myself as one user of health care provider or the whole community, I think whatever we do, wherever we are going on this journey the Presi-

dent has set us on, I think that there is a proper place to review everyone's legitimate contribution and where it fits in.

With that, I have no further questions, Mr. Chairman. I yield back.

Mr. TOWNS. Congressman Mica.

Mr. MICA. Thank you, Mr. Chairman. Well, I can see the need to integrate some of the services you provide in mental health and professional services, chiropractic care, and pediatrics—I am sorry, podiatrists. And pediatrics. All different disciplines need to be a part of this plan, and integrating it into the final plan will be important.

I wanted to ask, if I could, Mr. Shaver, a question. As far as hospitals are concerned, in whatever we do, what do you see as the way we can bring down hospital costs, like one, two, three, if you were in our position?

Mr. SHAVER. Congressman Mica, the hope that I think is held out by several of the plans that have been proposed is that we create a seamless health care system, and so that we don't have just a hospital. And, in fact, many of the organizations in New Mexico are really integrated health delivery systems. And so that we need to look at the total expenditure for health care services, be they hospital care ambulatory care or whatever so that, once again, we look at the total picture.

Here in New Mexico, we have been able to make a number of advances in treating a lot of people on an ambulatory or outpatient basis. For example, about 60 percent of all the scheduled surgery in New Mexico is done on an outpatient basis. That saves the patient and the insurer money. It also saves our employer money in lost time off.

Savings can and are being made through continued linkages and utilization of buying cooperatives where the hospitals buy services and goods. Another issue is simplification of the process, the administrative costs that have to do with getting approval for rendering a service and getting payment for that service. A simplification of that will greatly assist.

There are many, too many employees in hospitals who spend their days, their entire day, getting the approvals and then processing the bills and following up on that. We hope that any system that you as Congress pass will have the issue of simplification in it.

We are very pleased thus far with the movement of the administration on the antitrust issues as well. The guidelines, while they are a start, will assist in letting the collaborative practices occur among hospitals and other providers where in the past that has not been possible, and, in fact, there have been some tremendous risks, at least, of antitrust litigation brought against groups who get together to try to keep down the cost and improve the quality.

So I believe there are a number of factors. One is the antitrust, another is tort reform. Those mentioned earlier are significant as well, and simplification, and then a fully integrated delivery system with linkages among community health care providers, both public and private, and tertiary care facilities and services as well. I think that will assist greatly.

A longer term one is the concentration on life-style issues. And I think some of those incentives that I referred to have to deal with we, as consumers of care, and our unhealthy life style, whether it is alcohol or drugs or people like me, who are—there is a new term, a politically correct term, for people who are heavy, and that is horizontally advantaged. And I am trying to keep up with all the politically correct terms. And so people like me, who need to become less horizontally advantaged, that there are real incentives.

Mr. MICA. Thank you.

Thank you, Mr. Chairman, I don't have any further questions.

Mr. TOWNS. Thank you. Thank you very much, Congressman Mica.

Let me just sort of raise this very quickly with you, I guess, Dr. Cohn, or actually all three of you. I will leave you out, Mr. Shaver, and come back to you next.

What provision would you like to see to ensure that your patients still have access to the kind of care you provide now? I am very sensitive to the fact that only 14 percent of the chiropractors are involved in HMOs, and I didn't get the percent in terms of the amount of podiatrists that are involved in HMOs, but it seems to me the number appears to be even smaller.

Dr. COHN. It is low, very low.

Mr. TOWNS. So what do you suggest we do to make certain, of course, that the kind of services that you would provide are included in whatever we decide to do here to sell the package?

Dr. COHN. Should I take that first?

Mr. TOWNS. I want all three of you to answer that.

Dr. COHN. It is simple. Open panels. I heard Mrs. Clinton say the other day any doctor who applies to belong to any HMO should be allowed to belong to an HMO. I applauded that tremendously.

I think if a doctor includes any licensed physician, podiatrist, chiropractor, psychologist in the State, if we can join any HMO we want, that will eliminate a large part of the problem. It will not get rid of it completely but it sure will help.

The problem is when you ask for an application, generally you are told, no, we don't need you here, and that gets pretty old and frustrating after a very short while.

Mr. TOWNS. Dr. Davis.

Mr. DAVIS. Chairman Towns, when I opened up my office in 1985, I was not blessed, as Dr. Merovka was, by having five HMOs at my door. We just are looking for freedom of choice, actually. We feel like we have something to offer the community for health benefits and we believe that the research is in which indicates that and we feel like—we feel that economically this will be a very viable thing for the country to move toward, this type of approach of health care where it is less surgical and pharmaceutically based.

And we are just looking to have that sort of freedom in our health care delivery system.

Mr. TOWNS. Thank you.

Dr. Naranjo.

Dr. NARANJO. Chairman Towns, our situation is somewhat different, and when I say ours, I differentiate practitioner from our consumers.

Our practitioners, my colleagues, clinical psychologists and psychiatrists, are included and there is limited coverage. Historically, there has always been limited coverage depending on diagnostic code or a specific illness.

The consumers I am concerned about are the severe mentally ill, who literally, in some cases, have, as a result of their illness, have caused their families to go broke. Funds that have been saved for retirement have been spent on in-patient psychiatric stays and so forth. And I think a national health plan has to recognize that you cannot debilitate a whole family as a result of one illness. And you have to recognize that it is an illness. It is not a choice.

And right now you have heard other professionals here saying that Medicaid, Medicare pays poorly, and there is just a mass of paperwork. That is true, but for us, in most instances, that is the only game in town. And our programs are leveraged, if you will excuse me, to the hilt on Medicaid dollars. If you cut Medicaid, we are dead and our clients are back on the street, in jail or in psychiatric hospitals.

We have been forced to move to where the dollars are at so we can provide services, and Medicaid is one of those sources. A lot of our folks cannot access private practitioners because they will not accept Medicaid, for a lot of reasons, some of which have been mentioned to you. So it is not a field, per se, as much as it is a specific illness. And the mentally ill can be worked with and can learn to live in the community and can live good productive lives and improve their quality of life so their families are not ashamed of them and they can come out of the closet, in some cases actually be employed and contribute to our tax base.

Mr. TOWNS. Thank you very much, and thank all three of you.

This is for you, Mr. Shaver. In the training of specialists versus primary care doctors, are you concerned about the move to a 50–50 ratio rather than the current 70–30? And how do you respond to the President's recommendation to dramatically reduce graduate medical education reimbursement to hospitals as a means of helping to pay for the cost of the new health plan?

Mr. SHAVER. Chairman Towns, clearly the issue of providing for more primary care physicians is important. I don't know the specific details, Mr. Chairman, of the President's proposal, and those details could make my statement very different if I knew those. Encouragement, for training more primary care physicians including the payment mechanism, and as I understand the proposal will provide larger payments for primary care residents than for specialty physicians. I believe that would be a positive item.

New Mexico is blessed with having a university medical school which has emphasized primary care. There are still the problems that Dr. Merovka speaks of, but I believe there is some opportunity there. An added problem that I don't know how it will be dealt with is, if we have a lot more primary care providers available, what incentives are built in to get them where they are needed?

So not only the educational system must change, but the infrastructure support system for the doctor that goes out to a very small community in New Mexico. Such support can include locum tenens, a doctor that comes in and takes his or her place for a week or two so they can get away, cover the weekends and attend con-

tinuing education, as well as some other infrastructure systems to support the primary care provider in his or her practice, especially in underserved areas, whether they are urban, inner city areas or rural areas.

So I think it is a start, the funding mechanism. There are some real concerns on our part about the amount of savings that are identified in the Medicare and Medicaid system to help fund the proposal. I don't know whether those kind of cuts can be made and provide services to the patients that need those services, and especially those with very special needs, whether those are mental health needs or they are physically handicapped needs.

But I think it is a start to change the funding mechanism, because it is my understanding in some other States, where the State legislature says you will have a certain percentage of family or primary care residents, those medical schools have been able to adapt.

Fortunately, here in New Mexico we are quite a ways ahead, I think, of other States in the emphasis on primary care and some mechanisms. We do have some dollars from Robert Wood Johnson Foundation, for example, for our locum tenens program to help physicians who are out there wherever in New Mexico and needs a break.

Mr. TOWNS. Well, you know, as I think about what Dr. Merovka said earlier, we have to do something to address this. This is a very serious situation, and for a lot of reasons.

No. 1, I think if we want to make this work, we have to somewhere attract more primary care physicians. And one way would be to adjust the salary, is one way, and the other way would be in terms of after they come out, maybe if they practiced in an area, a primary care physician, in an underserved area, maybe we could eliminate a portion of the tuition loan. Maybe that is something.

We need to do something to begin to attract physicians. Because I know in the area I come from it is a big social thing, too. If you are at a party and you say that you are a doctor, the next question is "What is your specialty?" So these are things that have to be dealt with.

And the last thing I guess I should have asked the other panel, but physician assistants. I have not heard them mentioned at all. Do you have that out here?

Mr. SHAVER. Mr. Chairman, New Mexico has been a leader in the use of both physician assistants and nurse practitioners, and they do provide a lot of care throughout this State. Clearly, they must be a part of any delivery system.

By the way, New Mexico does have a loan forgiveness program for a physician going to an underserved area, also for nurses. Also, the University of New Mexico is expanding its rural family practice residency program outside of Albuquerque because there is strong evidence that where a person does their residency greatly influences where they practice.

So I can't emphasize enough the issue of medical education and other professional education needs to be in the plan some way, and probably just including it in the regular payment system is perhaps not well targeted enough as we have had in the past.

Mr. TOWNS. Let me thank all of you very, very much for your testimony.

Any other comments from the members?

Thank you again for your testimony. You have been extremely helpful, Dr. Cohn, Dr. Davis and to Dr. Naranjo and Mr. Shaver, thank you very, very much.

Mr. TOWNS. We will now call our third panel. Jerry Walker, Association of Commerce and Industry, representing NFIB; and Don Sikoro, representing AARP.

Let me begin with you, Mr. Walker.

STATEMENT OF JERRY C. WALKER, PRESIDENT, ASSOCIATION OF COMMERCE AND INDUSTRY

Mr. WALKER. Mr. Chairman, thank you very much and good morning to you and welcome, Mr. Chairman, to New Mexico. Congressman Mica, welcome to you. Welcome home, Representative Schiff, we are glad to have you.

Mr. Chairman, let me begin my remarks by clarifying something here. I do not represent NFIB. I was the director for NFIB for the previous 6 years. For the last 12 months I have moved over as president of the Association of Commerce and Industry, and so I am not here representing NFIB at all.

It seems as though when you take on a position of a small State like New Mexico, it tends to stick to you like bubble gum and that is all I can tell you.

Mr. Chairman, I, like Mr. Shaver, have changed my testimony somewhat following the address Wednesday evening of the President and the unveiling of his basic concepts of his program and have included and given to your staff some additional remarks concerning my comments there. I will not, in view of the time this morning, even begin to try to read the comments that I have submitted to the staff. I would like to just hit the high points very quickly and then stand for questions or comments from the committee.

No. 1, ACI, the Association of Commerce and Industry, fully well recognizes the need for health care reform here in the United States, but we also would ask that the Congress, as you go about developing the health care reform package that is going to ultimately be adopted, respect the rights of employers in their dealings with their employees. We think it is very, very important to recall that.

There were four issues in my written testimony that I wanted to bring before you this morning, one being the effect of State mandates on any managed care program or indemnity program in a State; second, the problems of availability of managed care in rural States such as New Mexico; third, the limitation of freedom of choice of physicians by consumers of HMO products; and finally, the tax equity issue for small businesses.

Unincorporated businesses. I don't think I have to walk you through this. I am sure you have heard this many, many times over. In States where constituents and special interest groups have gone to the State legislature and successfully had mandates adopted, mandated coverages adopted in health care plans in that State, we have seen the cost of insurance go up. The cost of coverage go up.

We think it would be very ill-advised for the Congress to go through a great deal of effort and work in adopting a national plan, but not close the door and leave a loophole where States can come in on top of the basic coverages that the Congress would set in the national plan and allow for those States to up the ante some and impose additional mandates on the people who are going to be paying for the cost of that coverage. And under the Clinton plan, of course, they are looking to employers as being the payor, the payer, of the premiums.

So at the risk of trouncing upon States' rights, I would hope this committee would at least carry back some kind of idea and message that maybe the ability of States to mandate additional coverages on top of the basic level of coverages that are set in the national plan be looked at.

Second, Mr. Chairman, was the issue of availability. You have heard that discussed here quite a bit this morning and I will not be repetitive. We at ACI are looking at and have been looking at offering through our membership HMO products to our employees all across New Mexico, and one of the problems that we have found in trying to offer an HMO to our members is the fact that across this State there are some big holes in coverage.

You have heard it talked about this morning. Basically, in the Rio Grande corridor, from Santa Fe down to Socorro, roughly, there is pretty good coverage. But when you get over on the eastern side of our State, from the northern border to the southern border, there is a huge gap. Very little coverage there available through HMOs. The same holds through from the northwestern corner to the southwestern corner. Except for the San Juan County area, there is very little HMO coverage available there. So availability is a big issue when it comes to trying to offer this type of coverage to a rural State like New Mexico.

Third, was the issue of choice of physician. As I say, we are considering offering an HMO through the Association of Commerce and Industry to our members for them to provide for their employees, and one of the questions that has been brought up several times in talking to our members about it, is the fact that you lose the choice of physician, or so it is felt, whenever you signed up with an HMO.

New Mexico, being a small rural State, there is a lot of personal loyalty to physicians here in this State. And I think Mr. Schiff can certainly attest to that. Our members are saying, look, Jerry, it may be a good idea to offer an HMO. This may be the way to go, but are we going to then be telling our employees you have to use the company doctor and there is some fear out there of that.

So that is an issue, as you work through the mechanics of a national plan, that is an issue that will have to be dealt with, because I don't doubt you will find that issue in other States as well.

Finally, Mr. Chairman, an issue that I wanted to discuss was the tax treatment for premiums paid by small employers, and I am speaking about small unincorporated employers. Under other Federal tax code, corporations have been able to deduct the cost of providing health insurance coverage for their employees, and that includes the officers and owners of corporations.

However, on the other side of the coin, the unincorporated small employer, while being allowed here just recently a percentage of a deduction for their premiums, is not given that same treatment under our tax code.

This may seem trivial to some folks, but I can assure you in a State like New Mexico, where 80 percent of our employers are small employers, and many, many of those are not incorporated, fairness is a big issue. So I would ask that the committee, as you are putting together your recommendations back to the Congress concerning any kind of a health care proposal, take a look at equity in the tax treatment that is given to small businesses, unincorporated businesses, under the plan.

Mr. Chairman, I did have a chance, of course, to see the President's address on Wednesday night. I was in California, and that is why it was kind of hard to get all these exhibits in one package together to you. I flew in last night. But I would like to just address a couple of things concerning the President's plan, from what I understand.

No. 1, I believe it is going to cost some jobs. We are in favor, we recognize the importance of health care reform in this country. But when you start mandating employers to provide that coverage, I think you are going to cost some jobs.

My wife, who is an entrepreneur who does employ five people here in New Mexico, has taken a look at the plan and said, look, if I am forced to provide coverage and pay for it, then I am simply going to reduce by one person the people in our small company. We are small, and I think you can magnify that across the State of New Mexico many times over and you will see a job loss in this State as a result of mandating employer coverage. So that is one area I certainly have some concerns with.

In the proposal, if I understand it properly, regional alliances are going to be utilized in order to constitute buying groups for insurance coverages. It is my understanding that there would be one regional alliance in a State such as New Mexico because of our population. It is my understanding that that alliance cannot go across State lines. It must be contained within a State boundary.

The problem I have with that, and the concern I have with that is that large corporations who have 5,000 or more employees enrolled in their coverage plans could be exempted from having to purchase their coverages through alliance. Unions are also allowed an exemption and will not be forced to purchase their coverage through the alliance. If that is the case, and I think in fairness, we should certainly take a look at allowing employer associations to also be granted the status of an alliance so that they can go out and negotiate the best purchase price they can get for coverage for their members and employees.

I believe, Mr. Chairman, that the American marketplace will respond to the pressures a free market system brings upon it through competition. If we are forced to buy coverage through a monopolistic alliance in New Mexico, I think you will be possibly hurting the very effort that you are trying to accomplish.

Finally, Mr. Chairman, again at the risk of trampling upon States' rights, I believe that it would be prudent for this committee to take a look at possibly recommending that a State not be al-

lowed, once this package is put together, to come up with a single payer scheme in a State such as New Mexico. A single payer scheme in New Mexico would be about a $4 billion industry that the State would be trying to manage. There are legislative committees looking into this very thing throughout this summer and traveling around our State.

Leaving a State like New Mexico the ability to come up with a single payer scheme is like handing them a loaded gun, in my opinion, and I think we have to be very, very careful in allowing that. And, again, I am an advocate of States' rights. It may not sound like I am much of one here this morning, but I think we have to build in some safeguards.

And those are the thoughts I have on the President's plan as outlined on Wednesday night. I appreciate the fact you will leave the record open an additional 10 days for comment and further testimony, and will certainly try to gather these comments into one package and get them to your staff so that the record is more reflective of what I said here this morning.

Mr. TOWNS. Thank you very much, Mr. Walker.

[The prepared statement of Mr. Walker follows:]

Presentation By
Jerry C. Walker, President
Association of Commerce & Industry

To The
Subcommittee on Human Resources
And Intergovernmental Relations

September 26, 1993
Albuquerque Convention Center
Albuquerque, NM

Mr. Chairman and Members of the Committee;

Thank you for bringing your committee to New Mexico and giving our citizens the opportunity to discuss the important issue of Health Care Reform with you. I personally wish to offer my thanks for being ask to appear before you today.

Before getting to the issue of Health Care Reform, and more specifically, Managed Care, please allow me a few moments to brief you on The Association of Commerce & Industry. The Association of Commerce & Industry (ACI) was formed thirty-four years ago and is recognized as the business voice in the State of New Mexico.

Our membership is dynamic and represents the diversity of the private sector. We have members as small as one-person firms, up to the state's largest employers having in excess of 5000 employees. Every local Chamber of Commerce in the state is recognized as a reciprocal member of ACI, and most of the local economic development entities and small business development centers across the state are working partners with our association.

I am here today to tell you that the Association of Commerce & Industry recognizes the importance, and indeed the necessity, of health care reform. I am also here to ask that the Congress remember and respect the rights of employers in their dealings with at-will employees. I am not an expert on HMO's, PPO's, or on the health care system in general. Therefore, I will restrict my comments to recurring issues and themes that have been discussed in our state over the past several years.

There are four issues that I would like to address this morning. The first is the effect of **state mandates** on the cost of all insurance plans; secondly, the problems of **availability of managed care plans** in rural states such as New Mexico; third, the **limitation of freedom of choice of physicians** encountered by consumers of managed care plans, and finally, **equal tax treatment** for small businesses.

State Mandates: Legislators in many states across the nation, in response to constituent pressure and demands of special interest groups, have mandated insurers to provide for different types and levels of coverage and services. New Mexico has been no different. Regardless of whether a particular coverage should or should not be included in a health care policy, the fact remains that mandates drive premiums up.

Federal exemptions allow certain large employer-provided insurance plans relief from state mandates. This is not true for plans utilized by most small businesses and New Mexico is a small business state. There are approximately 36,500 businesses currently operating in our state. Over eighty percent (80%) employ twenty or fewer employees. This high percentage of small businesses, when combined with our low personal income, may be a factor in the estimated high percentage of uninsured citizens in New Mexico.

If the Congress and Clinton Administration is, in fact, going to adopt and implement Health Care Reform containing a basic level of coverage, I would suggest that it might be prudent to look at placing restrictions on state imposed mandates. It will do the Congress and the American people little good if significant managed care reform laws are circumvented by costly state mandates.

Availability: The HMO or PPO concept apparently works well in urban areas of the country and here in New Mexico. However, many parts of our state are not served by managed care programs. I can't say with any degree of certainty, but I assume this is due either to the sparsity of our population in rural areas of the state, the unwillingness of health care providers to enter into agreements with managed care companies, or both.

A look at the coverage map of most HMO's operating in the state finds all of them covering the middle-Rio Grande corridor from Los Alamos in the north down to Belen or Socorro in the south. From Socorro there is generally a gap in available managed care programs until you get to Las Cruces and Dona Ana County. There is a huge gap all along the eastern side of the state from the northern to southern borders. The western side of the state reflects the same, except for a couple of programs that are just now being placed into operation in San Juan County.

To effectively provide managed care services to all portions of a rural state, such as New Mexico, may be a major challenge to the Congress and Administration. If that is the goal, then either the public or private sectors will be placed in a position of providing subsidies to these service providers in order to accomplish what now appears to be costly and undesirable.

Choice of Physician: One of the major cost saving components of an HMO or PPO program is the ability to contractually set fee schedules with physicians. This is one the strongest arguments in favor, as well as against, managed care programs.

In small states like New Mexico, loyalty to personal physicians is strong. The Association of Commerce & Industry has been the exclusive sponsor of a group health indemnity plan in New Mexico since the mid-80's. In visiting with our members around the state and asking their opinions concerning the possibility of offering an HMO plan, I have had concerns expressed to me -on more than one occasion- of the potential for losing choice of physician with a managed care plan. This is not a problem with our current program.

As a primary advocate of the free enterprise system, ACI in no way endorses mandating participation by health care providers in any manner. We recognize, however, that the issue must be addressed if any program is t be successful.

Equal Tax Treatment: Small business owners who are not incorporated have been discriminated against for years by the federal tax code not allowing for a full deduction of insurance premiums paid to cover themselves. These small employers have been allowed to deduct the cost of insurance premiums paid for their employees, but

have had to pay individual income taxes on their own premium costs.

A recent change has allowed a portion of the premium to be deducted, but the unfairness still exists. A small business owner is not precluded from spending several hundred dollars and having his/her business incorporated, and having a full (100 percent) deduction for their own insurance premium, plus that provided for employees.

This may seem a trivial thing to some. But, in my ten years of speaking for businesses in New Mexico, I have learned that fairness is a major issue with most small business owners. Some of these owners are the ones who look at the tax code and the cost of health insurance and reject the notion of providing coverage for their employees because the corporations get a tax break, while they get to pay taxes for the same product. It's simply a matter of equity and fair play.

Mr. Chairman, in your letter asking me to testify before this panel today you invited me to make additional comments on the President's Health Care Proposal which was unveiled Wednesday night.

In general what I have read and heard of the proposal leads me to believe the plan will cause a loss of jobs. Small business owners, and again I remind you that New Mexico is a small business state, will most certainly reduce their workforce in order to have the dollars necessary to pay the cost of the mandated coverage.

You might ask what I base my comments on. I have to tell you that I am married to an entrepreneur currently employing 5 people in New Mexico. If the plan, as outlined on Wednesday night were adopted, my wife tells me she will reduce her employee base by one person. I feel this response will be widespread throughout the small employer community in our state.

A specific item in the proposal that I have been made aware of is the manner by which the "Regional and Corporate Alliances" are to be formed. As I understand the it, a single Regional Alliance (the spin doctors name for a buying group or co-op) will be created in each state. The Alliance will be responsible for negotiating the price of health insurance in each region. Unions will be allowed to have their own alliances. Companies with more than 5,000 workers will be allowed to form their own alliances. Each will be exempted from purchasing health insurance through the regional alliance.

What this leads to is the rest of the business community being forced to participate in a monopolistic buying group. If the law is going to allow for employee union exemption and large corporate exemptions, then it must allow for employer association exemptions.

Many associations, like the Association of Commerce and Industry of New Mexico currently sponsor group health plans for our members to purchase coverage for their employees at better than individual premium costs. Instituting a competitive environment in which the alliances operate, rather than creating monopolistic entities in each state follows one of the best American traditions of forcing the market to respond through free

enterprise pressure.

The only other comment that I have today is based upon the understanding that the President's proposal allows substantial latitude for state options. At the risk, again, of trouncing on state's rights, I would encourage you to include a provision that disallows any state creating a single payer plan. Allowing states to create single payer plans is like handing a loaded gun to some states and trusting that they will not injure themselves.

Mr. Chairman, all that I have heard and read leads me to believe that the minority plan put forth the week of September 13, 1993 may contain more elements that the business community is willing, and indeed, able to live with. I would encourage your committee to take a close look at this proposal and adopt as many elements that are contained in it as possible.

Thank you for bringing this committee to Albuquerque and listening to our concerns. At the appropriate time I will be happy to attempt to answer any questions.

Mr. TOWNS. Mr. Sikora.

STATEMENT OF DON SIKORA, COORDINATOR, REPRESENTING AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. SIKORA. Thank you, very much, for the opportunity to be here today to discuss managed care in the context of health care reform.

As you probably know, AARP has for the past several years said that we need health care reform. It must be affordable, it must be fairly financed, and it should contain costs and provide comprehensive benefits, including long-term care and prescription drugs.

Now, we definitely are very pleased that the administration has come forward with a plan. However, when you start talking to the consumers out there and the membership of AARP you start getting a little different viewpoint as to how things are.

We have a State fair going on right now in Albuquerque and one of the things that we have done is we have been talking to the people at the State fair and saying what do you think of the Clinton plan, and it has been rather interesting some of the remarks.

The remarks have been everything from, well, let's wait and see and get more information on it, to, well, it looks all right on the surface, but we really have to really look at it from the standpoint of what it will cost us.

When you look at it and you say, OK, well, what is wrong with the President's plan, it really boils down to two things: Lack of feedback and control.

We have heard a number of people here talk about the problems that doctors will experience, the problems that employers will experience. Well, that is true. From a systems standpoint we say the health care system is in crisis. Well, if you basically look at the discipline of systems, there are five parts to it. Input, process, output, feedback, and control.

The health care system has never had feedback and control. That needs to be put into the system. With that, we then have something that we can go back to and the community can look at it and say, OK, how do I know that my goals for access quality and control are achieved? How do I know that I can shop for care? You do this through information. Information has never really become available to consumers.

When you look at it from the standpoint of managed care, you say, OK, as a patient, do I want managed care or do I want some other form of care? In New Mexico we are a rural area, in many, many, many ways. If you look at Lordsburg, the chances of getting top notch care in Lordsburg is virtually impossible because there are not enough people there. So you have to have a different kind of mechanism that will allow you to get the appropriate care.

What is appropriate for Lordsburg would have to be analyzed and determined. What can we afford? And by the same token, what can we afford and can we get the care there even if we could afford it? Because some doctors will want to practice there and others will not.

The elderly, by and large, have not used managed care as much as they probably could. There have been certain impediments out

there. Many HMOs really do not want to deal with elderly because they consider the reimbursement rate too low.

Surprisingly enough, in New Mexico, we did a study of HMOs. In 1988 and 1989, we made 14 different recommendations. None of those recommendations have been implemented. They are the very recommendations that people talked about, such as low reimbursement. So many of us start saying, well, we made these recommendations before but nobody seems to pay any attention to them. Therefore, we keep wondering if we keep making these recommendations will anyone ever listen to us.

I think now is the time where people are going to listen. They are going to take a much better viewpoint and say, look, you know, it is time we started looking at things; it is time we started looking at alternative care situations; it is time we looked at different ways of handling the health delivery system.

In the testimony which you received, Horace Deets had mentioned that they are going to go to the people, the membership. Well, I, as a volunteer, have sat down and prepared what I consider is a good blueprint for health care reform. And basically what I am saying is that we need checks and balances in the system; that the American public is willing and wants checks and balances in the system. It does not exist now. It should exist in the future.

It is very clear that adequate and sufficient oversight of the quality of care delivered by managed care organizations is critical. Without that oversight, we feel that the costs can become out of hand very quickly. In fact, we are very concerned that the country can become very uncompetitive very quickly.

We are confident with appropriate standards, managed care organizations can and will make an important contribution to the range of choices available to consumers.

Mr. Chairman, thank you for the opportunity to testify today. AARP stands ready to work with you and your colleagues as we advance in the prospects of health care reform.

Mr. TOWNS. Thank you.

[The prepared statement of Mr. Sikora follows:]

Bringing lifetimes of experience and leadership to serve all generations.

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

MANAGED CARE

Presented by

DON SIKORA

AARP/VOTE STATE COORDINATOR

before the

Subcommittee on Human Resources
House Government Operations Committee

Albuquerque, New Mexico

September 26, 1993

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Good Morning. I am Don Sikora from Albuquerque. I am the New Mexico VOTE State Coordinator for the American Association of Retired Persons. Mr. Chairman, I appreciate the opportunity to be here today to discuss AARP's perspective of managed care in the context of health care reform.

AARP has had a long standing interest in the delivery of health care services in the United States. For the past several years the Association has been actively working to achieve reform of our health and long-term care systems. In our view, a reformed health care system must be affordable, fairly financed, and contain controls on expenditures. In addition, it should provide people of all ages with comprehensive benefits that include long-term care and outpatient prescription drugs.

Managed care is central to the President's health care reform proposal. With this proposal and its changes in health care financing and delivery come the potential for universal health care coverage for all Americans. With it also come many questions about how to best reform our health care system to meet the needs of our society.

In this context you have asked AARP to discuss the Medicare beneficiary experience thus far with managed care. Interestingly enough, Medicare's experience with managed care is relatively limited and there is very little data available that provide an

accurate picture of the beneficiary experience. In our testimony we have attempted to make the distinction between the experiences with managed care in the private sector and Medicare managed care and to draw what conclusions we can based the available data. Since the President's health care reform proposal allows Medicare to remain intact, there is an opportunity to broaden our knowledge of the effectiveness of managed care for Medicare beneficiaries, but we would caution that until more is known about how effective Medicare managed care really is, moving the entire Medicare program in the direction of managed care should not be encouraged.

Managed Care in the Private Sector

By combining the delivery of health care services with the financing of coverage, many managed care organizations have been credited with being cost-effective and capable of providing high quality, comprehensive care to enrolled populations. In addition, lower out-of-pocket costs for enrollees are intended to contribute to continuity of care by providing access and encouraging early detection.

Most of the relevant research pertains to one particular model of managed care -- HMOs. The evidence on other, newer arrangements, such as Preferred Provider Organizations (PPOs), that rely mainly on discounting fees and solo practitioners, is not yet available.

In theory, these more open models are intended to provide broader choices while still providing sufficient "management" of the care delivered to save health care dollars by avoiding the provision of unnecessary services.

Enrollment in managed care organizations for those under age 65 has grown in recent years. In 1992, HMO market penetration reached 17.3% of the U.S. population. The highest areas of HMO concentration are in California and Massachusetts, where almost one-third of the residents are enrolled in HMOs. In contrast, New Mexico has a penetration rate of 15.7%, somewhat under the national average. It is estimated that approximately 35% of the general population is eligible to use PPO plans. New Mexico's PPO penetration is about 22%.

One of the reasons that managed care enrollment has been growing is that employers are looking for ways to stem increasing health care expenditures for their employees. According to a 1992 report from the Foster Higgins Health Care Benefits Survey, both the average cost increase and per employee cost for managed care plans were significantly lower than for traditional indemnity plans.

For example, the study found that indemnity plans averaged $3,979 per employee. This is approximately 9% more expensive

than PPO plans at $3664 per employee -- and about 19% more expensive than HMO plans that cost $3,348 per employee.

The Medicare Experience

Similarly, the federal government has promoted enrollment in managed care organizations for Medicare beneficiaries in an effort to contain escalating Medicare expenditures. However, HMO penetration of the Medicare population is far lower than for the under 65 population -- only about 5%. In New Mexico, HCFA estimates that there are approximately 17,800 Medicare beneficiaries enrolled in risk HMOs, or about 9% of the state's Medicare population. Moreover, PPOs are not yet available to New Mexico's Medicare beneficiaries because Congress has only authorized 15 states (New Mexico is not included) to participate in a demonstration program, known as Medicare Select, which enables Medicare beneficiaries to obtain services through PPOs. Therefore, unlike those under age 65, Medicare beneficiaries have very limited experience and are relatively unfamiliar with managed care organizations. This is due, at least in part, to the fact that enrollment in these plans is not yet available in every part of the country. In addition, there is evidence of plan reluctance to participate due to reimbursement methodology that pegs Medicare risk payment to fee for service.

A recent study by Mathematica Policy Research, Inc. indicated that as of June 1992, participating HMO plans only served 40 different metropolitan areas across 28 states. Moreover, the bulk of the enrollees was concentrated in about only 15 plans. Until more Medicare beneficiaries have the opportunity to enroll in managed care organizations, it will be difficult to know with certainty whether this type of delivery system will find favor with the nation's older citizens.

Finally, states have also turned to the delivery of services through managed care for their Medicaid populations. As of June 1992, 235 organizations served roughly 3.5 million recipients -- about 12% of the total Medicaid population.

It is still not certain how effectively managed care organizations meet cost containment objectives. The absence of a consistent definition of "managed care" and the various forms managed care takes make it difficult to assess whether, in general, these entities generate significant savings. At the same time, AARP recognizes the importance of offering alternative delivery systems as health care options to a cross-section of the population including workers, Medicare beneficiaries, and Medicaid recipients. There have been numerous studies that indicate that the quality of care delivered by managed care organizations is comparable to that found in the fee-for-service sector.

As noted earlier, most of this research applies to HMOs. These results hold for commercial enrollees as well as public beneficiaries in Medicare and Medicaid. In some cases, there is even evidence that care for HMO patients was even better than under traditional coverage. On the other hand, most of us have also heard anecdotal evidence of less than ideal care provided by managed care organizations.

It is clear that adequate and sufficient oversight of the quality of care delivered by managed care organizations is critical, especially now that a substantial portion of the population can be expected to receive care through this type of model.

AARP believes that standards should be developed and enforced by the federal government to ensure that managed care organizations are fiscally sound. In the absence of rigorous standards, the very incentives that permit managed care organizations to operate efficiently, such as physicians risk sharing arrangements, can be misdirected. Therefore, we believe that the financial incentives that foster the delivery of cost-effective care should be encouraged so long as it does not create barriers to care or lead to underservice.

AARP has long advocated that Medicare risk contractors be required to have effective internal quality assurance programs in place and functioning at the time they are certified to

participate in the program, and that these internal review programs be supported by external reviews of the plans' delivery systems. External review programs are particularly important and, like an internal review system, should also be required for managed care organizations serving non-Medicare populations. We also believe that appropriate grievance and appeals mechanisms should be required in managed care settings to ensure that consumer concerns are received and attended to as quickly and responsively as possible.

We are encouraged by the recent recognition that consumers need more information about the health care system to make wise and effective decisions, and we support efforts to enhance consumer knowledge as a basis for making health care coverage choices. It is essential that such information be accurate, "consumer friendly" and readily available.

As the debate on health care reform proceeds, AARP will follow closely the progress of proposals that recommend the dissemination of uniform consumer information. We want to ensure that this information will empower consumers by enabling them to make informed choices to suit their individual needs. Likewise, AARP and policymakers must share the goal that as new ways of delivering services are introduced, the quality of care will not be compromised.

We are confident that, with appropriate standards, managed care organizations can and will make an important contribution to the range of choices available to consumers.

Mr. Chairman, thank you for the opportunity to testify today. AARP stands ready to work with you and your colleagues as we advance the prospect of health care reform.

Mr. TOWNS. Thank you very, very much, both of you for your testimony. At this time, I would like to yield to Congressman Schiff for questions at this time.

Mr. SCHIFF. Thank you, Mr. Chairman.

Mr. Chairman, because of the hour, I need to make sure we all get back to Washington and I will be very brief here. As with the other witnesses, I want to thank these witnesses for excellent testimony. I have known them both for many years, know of their experience in testifying on these issues.

Don, two things. First of all, I have looked through your testimony and I saw references to the study and the 14 points, but I don't know that it is right there and I would ask you just to make sure we have it for this record, because I think you are right, this is certainly the time to consider everything. If you could be sure to supply us within the next 10 days of that list—or sooner if you happen to have a copy available to you.

[The information follows:]

RECOMMENDATIONS AND IMPLEMENTATION SUGGESTIONS

Recommendation 1: That a yearly summary of all HMO benefits and costs be produced in a format specified by the State Insurance Commission.

Implementation: The AARP SLC should inform appropriate State Legislators and Committees that AARP would like the State Insurance Commission to issue rules and procedures to submit and publish data on HMO benefits and costs as soon as possible.

Recommendation 2: That AARP request assistance from the New Mexico Congressional Delegation in obtaining the method and data used in calculating the capitation levels for New Mexico from HCFA.

Implementation: That AARP's Washington Federal Affairs contact the New Mexico Congressional Delegation in Washington and the New Mexico HealthWatch team, with the help of the SLC, contact the local New Mexico Congressional Offices to explain the ramification of the recommendation. Because of the potential loss of several millions of dollars per year to people in the state, this contact should be a priority action.

Recommendation 3: That HMO's implement a plan to notify members of their rights concerning second opinions.

Implementation: The New Mexico HealthWatch team should continue its efforts to meet with the State Insurance Commission to request that rules and procedures be issued to the HMO's that they notify their rights concerning second opinions. A meeting should be scheduled as soon as possible.

Recommendation 4: That HMO's notify members about screening exams, immunization programs and Information/Education programs.

Implementation: The New Mexico HealthWatch team should continue its efforts to meet with the State Insurance Commission to request that rules and procedures be issued to the HMO's that they notify their members about screening exams, immunization programs and Information/Educa-

tional programs. This subject should be covered when meeting with the Commission on other recommendations.

Recommendation 5: That practitioners should inform enrollees concerning reactions and side effect for prescription drugs and medication.

Implementation: The New Mexico Health Care Campaign Committee should meet with the Greater Albuquerque Medical Association and the New Mexico Agency on Aging to formulate a plan to develop and distribute information on the side effects of prescription drugs and medication. Because of the grave dangers that exist for drug abuse, this recommendation should be a high priority for AARP and the New Mexico Agency on Aging.

Recommendation 6: That FHP and other HMOs improve their community relations with area practitioners.

Implementation: The New Mexico Health Care Campaign Committee should meet with the Greater Albuquerque Medical Association and a representative from each of HMO's in the area. Together they can explore methods and devise actions to improve their relationships. This initiative should be scheduled as soon as possible.

Recommendation 7: Require HMO's to publish External "Complaint Procedures".

Implementation: The New Mexico HealthWatch team and the SLC meet with the State Insurance Commission to request that rules and procedures be issued to the HMO's requiring they publish an External Complaint Procedure. As with the other implementation suggestions of concern, with the Insurance Commission this recommendation can be addressed at the same time as other recommendations.

Recommendation 8: Actively monitor capitation funding levels to HMO's from HCFA.

Implementation: AARPs' Washington Federal Affairs contact HCFA to establish how the data will be supplied to AARP so they can monitor the capitation funding levels. Contact should be made at the highest level so that the monitoring can begin as soon as possible.

Recommendation 9: Make public annually, the advertising and marketing expenditures of the HMO's.

Implementation: The New Mexico HealthWatch team and SLC meet with the State Insurance Commission to request that rules and procedures be issued to the HMO's which will require them to make public their annual advertising and marketing expenditures. This also can be dealt with in conjunction with the other issues listed above.

Recommendation 10: Complete the Medical Discipline Questionnaire and the Consumer's Guide to the Board of Medical Examiner's in 1989.

Implementation: The New Mexico HealthWatch team meet with the State Board of Medical Examiners to establish a plan to have the Medical Discipline Questionnaire completed and the Consumer's Guide prepared and distributed. This should be accomplished by the end of this year.

Recommendation 11: That the State require all Pharmacies to charge the lesser of the cost of the prescription drug or the co-payment.

Implementation: That the SLC meet with appropriate legislative staff to create laws that will require Pharmacies charge the lesser of the cost of the prescription drug or the co-payment.

Recommendation 12: As a condition of operation, the State, should require HMOs to issue written notice of all oral approvals of services within Twenty-four (24) hours.

Implementation: The New Mexico HealthWatch team and SLC meet with the State Insurance Commission to request that riles and procedures be issued that will require HMOs to issue written approval for services within Twenty-four (24) of oral approval, of the service.

Recommendation 13: That AARP sponsor a health care shopping guide for the consumer.

Implementation: The New Mexico Health Care Campaign Committee or AARP in Washington should develop the necessary Consumer Guides. With the many information sources available to AARP, this

shopping guide could be an added service to the public.

Recommendation 14: As a condition of operation the State should require that HMOs be held responsible for the coordination of services and primary care continuance when a HMO closes or is sold to another health care provider.

Implementation: AARPs' SLC and the New Mexico HealthWatch team meet with the State Insurance Commission to request that rules and procedures be issued that will hold HMO's responsible for coordination of services and primary care continuance when a HMO closes or is sold to another health care provider. This should be considered as a high priority action item that should be implemented quickly.

A significant factor that must be recognized is that Medicare enrollees and practitioners may have dropped out of a HMO because they were dissatisfied with the HMO performance. This study did not attempt to reach these people and thus is somewhat biased by creating a "snap shot" of the conditions as they existed at the time the data was gathered.

Mr. SCHIFF. Second, I have one question for you. The President has proposed, among other things, providing more services in Medicare. He has talked about providing prescription drugs through Medicare, which is generally not provided now, as you know, and has referred to long-term care, which one could argue is an extension of Medicare. At the same time, the President's plan, if you look at the figures, intends to withdraw funds that were intended to go to Medicare to put into this regional alliances. So there is a legitimate question here as to whether all these figures will add up. I hope they do if we adopt the President's plan in total, but I am really very skeptical myself.

Has AARP, as yet, to your knowledge, done any kind of examination of this part of the President's proposals to give us their input as to whether these figures all meet?

Mr. SIKORA. They have started to look at it. The big problem is how much credibility do the figures really have, and what kind of an inflation factor are we looking for and what kind of controls are we going to have from the standpoint of reimbursement levels?

Let me give you a case in point. If I go to a doctor and have cataract surgery, if it costs me $2,000 today and I pay 20 percent, that is $200. If all of a sudden that cataract surgery goes to $4,000, which is entirely possible, we have seen things like that happen, then my expense then is $400. So we have a lot more out-of-pocket expenses that are out there, and, also, more reimbursement out of the trust funds.

So there is a real question of whether there would be enough money to support almost any kind of increase in Medicare. We have to very carefully monitor our expenditures, which today, unfortunately, we don't have.

A case in point is a couple years ago I tried to get the information on HMOs from the Health Care Financing Administration on an episode-by-episode basis. It was denied. And the reason it was denied is because their records are not accurate. They finally agreed they were not accurate.

Well, until we get accurate reporting, we have to kind of question the very figures that we are getting and that is why I think AARP will be very careful in saying, yes, we support this or, no, we don't support it.

Mr. SCHIFF. Thank you very much.

Jerry, again, one comment and one question. First, the comment is I want to join you in expressing concern about the regional alliances as proposed by the President. I personally believe that regional purchasing alliances make a lot of sense in order to give small business and individuals greater purchasing power, but certainly what has been glossed over thus far is the fact the President's plan intends for almost everyone, not quite everyone, there are exceptions, to be compelled, to be forced to join a regional purchasing alliance which will be run by, for us, the government of the State of New Mexico.

Now, we are already paying a 6 cent gasoline tax because the government misprojected its own income being a bit facetious there, but I think I can fairly ask what expertise does the State of New Mexico or the government of any other State have in running our health care for us. That is a great concern to me, and I

am glad you have brought this out because I don't think it has been emphasized enough, the compulsory nature of joining these regional alliances.

But here is my question. I agree with you that mandated employer coverage, especially New Mexico, will cost a number of jobs. The government has the power to mandate coverage. The government does not have the power to mandate jobs. I am very concerned if a business has five employees and is compelled to provide coverage that they will say, OK, we will fire one employee and with that savings we will cover the other four.

I am not sure that is a net positive. Nevertheless, I equally share the President's concern about cost shifting. If in a particular business five employees are not covered, they are in auto accidents like anyone else, they get sick like anyone else, they are not denied treatment in our society. The fact of the matter is that cost is picked up somewhere else, largely by those companies, large and small, that do pay insurance premiums.

So if you agree that this cost shifting is a problem, what is your proposed solution for the situation where numerous small businesses at the present time do not provide health care coverage?

Mr. WALKER. Mr. Chairman, I would respond by saying that, No. 1, coming up with a package of minimum coverages that you stick to so that you have a known cost factor applied across each State would be very helpful. That gets back to the mandates that can be piled on top.

Second, apparently the administration is looking at some form of subsidy for the smallest of businesses to get them in the loop, to get them used to paying insurance premiums with a phaseout period over a number of years. I am not sure I am sitting here as a proponent of that today, but that is certainly one potential solution that you could bring to this problem.

In New Mexico, and I am being I guess rather myopic in my view of this, and looking strictly at New Mexico, as you are well aware, through our property taxes, through our other taxes that we pay, we are paying for indigent care in New Mexico today. So I would submit to you today instead of saying these other small employers are not paying for insurance premiums, they in fact are. In fact, they are probably paying more than they should be if they would go out and purchase a policy from someone, because what happens when you are dealing with the indigent type coverage, is these folks are waiting until they are going to an emergency room where it costs a whole heck of a lot more to receive some type of care, and then of course the indigent funds we taxpayers in this State fund are picking up that cost.

So I would say to you maybe they are participating in premiums. Maybe what they need to be looking at is being brought on-line through some sort of program. Maybe the President's approach in offering a subsidy over a short period of time in getting them used to building that into their budget is the proper way to go.

I don't have the answer, Mr. Schiff.

Mr. SCHIFF. Well, none of us have it entirely or we would not be having this hearing. I would like to thank both witnesses again and yield back, Mr. Chairman.

Mr. TOWNS. Thank you very much, Congressman Schiff.

Congressman Mica.

Mr. MICA. Well, we are getting to the end here and I have found this most enlightening. I was not familiar with managed care or HMOs and how they operate here.

Some of the problems seem pretty basic, though, and even in the HMOs, it seems like you have got the problem of administration and bureaucracy that is built into it, even though it is supposed to be more efficient, and then you have the problem, as you point out, sir, of the reimbursement, adequate reimbursement, and the problem of capping costs and still getting quality care. So we probably have raised as many questions, more questions than answers on how you develop a system.

I don't have a lot of faith in big government. It is just maybe some bad experiences I have had over the years, and, you know, the Soviet Union devised a great system of health care that covered everybody and all kinds of social programs that eventually brought it down. It does not seem to work. So maybe we can learn by the lessons of this experience.

I am still kind of concerned that we have to address the tort reform; the question of futile care. There is another question facing a lot of seniors as people get older, their systems start to fail and now we have the ability to keep them going. So I am coming away with just as many questions as answers. I appreciate your viewpoint.

And then the question of putting people out of work, the ability for businesses and people that are working, which are the only sources of our revenue, and eliminating more of them. So there are some tough questions.

That is not really a question from me but sort of a comment. I don't know if you want to respond.

Mr. SIKORA. Well, you know, actually, we have a lot of tough questions that have to be answered. But surprisingly enough, if we look at it and we say, OK, let's take them one at a time and let's be honest about them. We have to kind of put on the back burner sometimes who we work for and who we represent and look at what will do best for the American public, and to that end, I think we have to kind of jointly look at it and say, OK, how best can we succeed as a Nation in a global economy, and that will mean that we will have to take some different viewpoints and some different approaches to health care.

Mr. MICA. Thank you. Thank you, Mr. Chairman, I yield back.

Mr. TOWNS. Well, thank you very much, Congressman Mica.

Let me thank you, Mr. Sikora, and also Mr. Walker, for your testimony, and I agree with you, I think that there is still some unfinished business in terms of the plan and how do we get health care into rural areas to make certain those areas have the proper kind of coverage. There is a lot of things we need to do.

But one thing I think we can all agree on, any time we are spending 14 percent of our GNP and still have the kind of problems that we have, something needs to be done. We are spending like $862 billion, that is "B" as in boy, billion dollars, and still having all these problems. I think that we must go in another direction. And when you look at all the other countries, I think the highest

that has been spent is 10 percent of their GNP. So we need to do something to be able to correct the problems that we now have.

So we appreciate your comments and your concerns and, of course, we go back to Washington knowing that we have a lot of work to do, but we appreciate the information that you have given us. I think it will help us a great deal because our subcommittee will have some jurisdiction over that plan; that we will be in there, and of course this information that you have given us will be very, very helpful.

So let me thank all of you for your testimony and let me thank you, Congressman Schiff, for your commitment and your dedication in making certain that we had an opportunity to hear from the people of Albuquerque, NM; thank you, Congressman Mica, for coming from Florida to be a part of this day as well.

So at this time let me say the Committee on Government Operations, Subcommittee on Human Resources and Intergovernmental Relations will now conclude with the note that the record will be open for 10 days.

[Whereupon, at 12:18 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

85-840 O - 95 - 5

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Greater Albuquerque Medical Association
7770 Jefferson, N.E.
Albuquerque, New Mexico 87109
October 5, 1993

The Honorable Edolphus Towns
U.S. House of Representatives
2232 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Steven Schiff
U.S. House of Representatives
1009 Longworth House Office Building
Washington, D.C. 20515

Dear Congressman Towns and Congressman Schiff:

I would like to sincerely express my gratitude for the opportunity to have provided testimony to the House Government Operations Committee, Subcommittee on Human Resources and Intergovernmental Relations, in Albuquerque on September 26, 1993, on the topic of Managed Care. I am sure that I speak for all those present by saying that your willingness to journey to Albuquerque to hold this hearing was very greatly appreciated, and reflects a recognition that Albuquerque's experience in the competitive medical marketplace may provide valuable insights to those who seek to further improve our nation's healthcare delivery system.

I am afraid that I failed to give a well thought-out answer to a question you posed concerning suggestions for meaningful tort reform. I would like to take advantage of your generous offer to allow additional written testimony by appending the following brief comments to my prior answer:

There has developed in this country an expectation of perfect outcomes, that technology can consistently perform miracles and cure all ills. In the context of medical care, there is the sense that blame must be assigned whenever there is an adverse outcome to an illness, or to a natural life event such as a pregnancy. In parallel, we have promoted the concept that anyone who is injured is "entitled" to his or her day in court, without regard to the costs involved. Those costs are borne by all of us, and those who stand accused pay a particularly heavy toll, regardless of the merits of the accusation. As a society, we might say that these costs are justified if all those injured were justly compensated, and if the system of litigation truly brought about improvements in efficacy and safety. Unfortunately, judged by these standards, there is overwhelming evidence that the tort system is a dismal failure. Only a tiny percentage of those who are injured receive compensation, often in the form of bonanza awards that have given the system the allure of a giant lottery. It is widely accepted that juries in malpractice cases make decisions based on sympathy for the defenseless injured and the relative credibility (i.e. performances) of "expert" witnesses, and not based on esoteric scientific arguments which juries are totally unequipped to evaluate. This state of affairs has done nothing to inspire better medicine, but has done much to strike non-productive fear into the hearts of all physicians. There is no evidence that the tort system has been at all effective in weeding out the "bad apples," but all of us know very fine physicians who have given up medicine after being sued. It is impossible to estimate the true cost of "defensive" medicine, because the defensive mentality has become so ingrained in

virtually all aspects of medical care. Not the least of the extremely destructive consequences of this mentality has been its effect on the physician-patient relationship. Patients are seen (especially by physicians who have been previously sued) not as partners in an alliance to promote or restore health, but as potential legal adversaries. The therapeutic goal then becomes distorted into "how do I best protect myself", not "how do I do what is best for my patient." For example, many physicians refuse to care for high risk patients. A great many excellent obstetricians in New Mexico have completely given up delivering babies. Is this what the tort system intends to accomplish?

If we are to truly make medical care more cost effective and more rational, we simply must recognize that the malpractice liability system is an enormously costly failure. We must critically re-examine the concept of a constitutional "entitlement" to one's day in court, without any corresponding protection for those who may stand unjustly accused except for the enormously expensive and devastating experience of "proving" one's innocence. Incentives for frivolous lawsuits (which are often "settled" rather than fought because settling is a great deal cheaper) simply must be removed. I don't pretend to have detailed legal remedies at hand, and would leave development of those solutions to those who are much more expert than I. But here are a few ideas:

- Compel the losing side to pay the legal costs of the winning side. This might be most effectively implemented in the setting of a medical-legal panel, if a suit is brought in spite of a decision by the panel that there is insufficient cause. Most frivolous suits would quickly disappear.

- Consider development of a "no-fault" type of compensation system. If we took all the money spent on litigation and used it to compensate those severely injured by illness or adverse outcomes, we would come much closer to the goal of compensating all those who were truly deserving.

- Strengthen peer review authority. Presently, the ability of the medical profession to effectively police itself is greatly diminished by the fear of restriction of trade litigation.

- Enact limits on non-economic damages. The "lottery" aspect of the tort system is grossly unfair and only promotes more lawsuits.

- Strengthen provisions for alternative dispute resolution. Include mechanisms whereby a physician could be judged by those truly competent to understand the issues at hand.

Thank you very much once again for your consideration.

Sincerely,

Steven P. Kanig, M.D.
President Elect, Greater Albuquerque Medical Association

Albuquerque
Psychiatry and Psychology Associates, P.C.

Allen A. Hovda, M.D.
Robert T. Kellogg, M.D.
Thomas R. Carey, Ph.D.
Joan B. Scott, Ph.D.
Roger H. White, Jr., Ph.D.
Clara Farah, Ph.D.
Richard B. Smith, M.D.

September 21, 1993

Congressman Steven Schiff
1009 Longworth Building
Washington, D.C. 20515-3101

Attention: Jim Stin
Fax #: 202-225-4975

Dear Congressman Schiff:

Thank you for your letter of September 14, 1993, in which you requested my opinion about the HMO's and managed care.

Briefly, about myself without a prolonged resume, I am a 69-year-old physician, receiving my degree from Ohio State in 1948 and completing my residency in Psychiatry at the University of Minnesota (VA Hospital) in 1959. I served in the U.S. Navy Reserve for 4½ years both as a Hospital Corpman in World War II and as a Medical Officer during the Korean Conflict. I have experience in the VA Hospital, the University of New Mexico Medical School, and other health organizations, but mostly have been in private practice as a general practitioner in Wisconsin and as a private psychiatrist since coming to Albuquerque in 1959.

The HMO's and managed care are, in my opinion, unfavorable in the context of the patient and their family not being in a strong position. Also, it weakens the strength of the patient/doctor honest dialogue. Like any system of healthcare, it is as good as the ethics and policies, etc., of its leaders. Corruption and greed can be present with the largest or smallest of organizations. The small group practice, as I am in, may lose the autonomy and the customized treatment under large HMO (capitation) or managed care.

Managed care is a good concept when the peer review doctor and the responsible physician agree on the diagnosis and treatment plan, but since medicine is both an art and a science, the doctor in San Francisco, California or Newark, New Jersey

may not approve of my referral of a Navajo Indian to the Navajo Medicine Man or the patient whose cultural heritage or personality traits do not fit the most acceptable therapy approved by academic medicine.

When differences occur without resolution of the third party peer review or the third party payor, they may arbitrarily set limits on the attending physician or hospital without the responsibility to the consequences. This leads to the responsible physician being left with having the responsibility but not the authority. Peer review groups and third party payment (those who pay the bills control the treatment) forces me to provide at times services for free or lengthy appeal process.

Managed care coming from a local area is less disruptive than distant managed care groups. HMO's who have a strong political public relationship program frequently distort their advertising, where the small group does not have the money to advertise and market their program, and must rely on the traditional patient referral source and reputation in the community.

A personal example may explain my position. In December of 1992, my wife had a mammogram which was considered normal. She has a history of fibrocystic disease (non-malignant lumps in the breast) which makes it difficult for any conscientious physician to determine minor changes, but since she is very aware of her own body, she returned to her physician in August of 1993, and he, with ambivalence and with her insistence, did a biopsy. The biopsy supported cancer of the breast and bilateral mastectomy with additional treatment is scheduled to begin on October 5, 1993.

This experience under the HMO or managed care would certainly possibly be considered as good medical practice if questioned in reference to the necessity of a biopsy at this particular time. Possibly repeat of the mammogram in December 1993 would be an appropriate thing to accept, but because of my wife's self-awareness of her body and the doctor who listened, a biopsy was done, and the cancer was caught at its very earliest of stage with an excellent prognosis. The HMO or peer review group may not directly be knowledgeable of the person, my wife, or the open dialogue with which she is able to communicate with her doctor (doctor/patient relationship). Certainly, it might be considered excessive treatment if the biopsy had returned normal, and this would be the kind of a situation where the doctor or hospital may be judged as being excessive and monetarily driven and financially be questioned. This is the down side of HMO's and managed care.

I agree the cost of the healthcare system must be addressed, but at the same time I am encouraging that in this process of formulating the equation for making the decision that the patient be in the most powerful position of that equation and the responsible clinician and the patient not be just the subordinate of an HMO or a peer review group. Those who are making the decision should have more responsibilities in my opinion, and I am referring particularly to the HMO's who are controlling indirectly the care of the patient or the managed care organizations who are many times controlling the care of the patient, but if a situation turns sour, seemingly have no responsibility, but it is then challenged that the responsible clinician or the patient has not adequately presented their case clearly.

This permits the HMO's and the peer review group to be in a luxurious position and keeps the patient and the physician in a potentially weak position to give the best care to the patient. I am not opposed to change, I just don't want to throw out the baby with the bath water.

Respectfully submitted,

Allen A. Hovda, M.D.
F.A.P.A.

AA:sek

P.S. I hope to see you Sunday.

Randall P. Maydew, M.D.
500 Walter N.E. Suite 409
Albuquerque, New Mexico 87102

October 4, 1993

The Honorable Steven Schiff
United States Congress
House of Representatives
1009 Longworth Building
Washington, D.C. 20515-3101

Dear Congressman Schiff,

I regret having missed your Subcommittee on Human Resources and Intergovernmental Relations hearing but I appreciate the opportunity to provide written testimony. I believe that the subcommittee's decision to hold the hearing in Albuquerque was a wise one as our market penetration of HMO's is very high as you well know. I have witnessed the growth of contract health care in Albuquerque for the past ten years.

HMO's have provided a necessary product in this market as is evidenced by their steady increase in membership. They provide medical coverage for the inexperienced medical consumer. They are very attractive to the relatively healthy young families on a budget as the monthly expenses are much more predictable than indemnity plans. As these individuals have few chronic ailments and few longstanding relationships with health care providers, they are generally not concerned if they see a different doctor in the clinic nor do they possess the knowledge to insist on care by a specialist. Dissatisfaction usually results from failure of initial treatment by their "gate keeper" physician and perceived delay in treatment by a specialist.

The majority of HMO's are structured to channel members into the initial " gate keeper" review, i.e. primary care physicians. This is in order to limit unnecessary specialist care. It is important for the committee members to understand that most HMO's financially reward their gate keepers who successfully limit access to speciality care. I personally feel that this is an important conflict of interest. I would like for referals on my condition to be predicated solely on knowledge, or lack there of.

Another interesting subpopulation of HMO members are the Medicare/HMO's. These individuals join an HMO often with the promise that they will pay little or no more that what Medicare will reimburse. They are generally lower income Medicare beneficiaries and are often the more complicated medically. They will put up with the inconvienence of rapidly changing primary care physicians for the financial security of limited expenses.

HMO's conduct the delivery of health care as a business as you would expect. My experience has shown that long standing doctor-patient relationships are a distant second to the bottom line. As with any business, HMO's work to limit their expenses and willingly change providers if they can provide the services less expensively. I am providing this information as a reflection of the marketplace and reserving all judgement.

HMO's limit access to physicians in return for lower price and / or decreased paper work. They have filled a necessary nitche in the Albuquerque marketplace and I expect that they will have a place in any form of health care reform. Thank-you for the opportunity to comment on these issues. If I may be of further assistance to the committee please let me know.

Sincerely,

Randall P. Maydew, M.D.

U.S. HOUSE OF REPRESENTATIVES

GOVERNMENT OPERATIONS COMMITTEE

SUBCOMMITTEE ON HUMAN RESOURCES AND
INTERGOVERNMENTAL RELATIONS

"MANAGED CARE: AN IN-DEPTH EXAMINATION."

Written testimony of
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Albuquerque, NM

Derick P. Pasternak, M.D. 30 September 1993

Many proposed approaches to health care reform lean heavily on managed care mechanisms to ensure quality heath care at an affordable cost to increased populations. Therefore it is highly appropriate for Congress to inquire into the effectiveness of managed healthcare in a community with high penetration of such care, namely Albuquerque, NM. Unfortunately, the witnesses on 26 September 1993 for the most part represented organizations that have reason to be critical of managed health care because of the narrow interests they serve.

I offer testimony on behalf of Lovelace Health Systems, an integrated health care system, delivering both care and financing to people in all three Congressional Districts of New Mexico. Of the HMO subscribers in the State, approximately half are members of the Lovelace Health Plan and our delivery system serves these members and other New Mexicans, reaching one in every eight residents of the State.

The Lovelace Health Plan came into being in 1973, became federally qualified in 1981 and was reorganized as a for profit corporation in 1985. Between 1981 and 1993 in grew from 5,000 to 122,000 members, not including Medicare members under a variety of contracts. During these years of growth, voluntary disenrollment rate was less than 7% every year and the Plan did not lose a major employer group until 1992. The plan has conducted careful member satisfaction surveys on a yearly basis; these have consistently yielded "satisfied" and "very satisfied" answers approximately 90% of the time.

Our employer clients include all levels of Government (Federal, State, Local), large employers who contract with many managed care plans nationwide as well as small employers in a single location; we make the Lovelace Health Plan available to individuals through selected trade associations and through a special vehicle, designed to comply with New Mexico State Law which was aimed at reducing the number of New Mexicans who had no access to traditionally designed health plans (Care New Mexico). Lovelace has been the only organization offering Care New Mexico since it was established by the Legislature in 1992.

In this market, managed care plans have attracted increasing number of enrollees partly because of economic factors. As indicated in testimony on 26 September, insurance rates for HMO plans have risen consistently less steeply than rates for indemnity plans. At the same time, the quality of care provided in these plans is equivalent to that provided in traditional plans. The preponderance of evidence available from nationwide studies

confirms this. Locally, in Albuquerque, hospitals have convincing data verified by the Joint Commission on Accreditation of Healthcare Organizations that care of patients within their walls is of equivalent quality, no matter what the financing mechanism. On the outpatient care side equivalence is more difficult to demonstrate, but the majority of HMO's operating in this market are in fact highly selective, applying strict quality criteria to physicians and other providers selected to be on their panels. It is quite evident from the action of the enrollees, that the improved affordability coupled with equivalent quality they see in managed care plans outweighs the unrestricted choice of providers that traditional indemnity plans continue to offer.

There is another factor in the evaluation of managed care plans that was not addressed in any testimony on 26 September. This is the role of managed care plans in technology assessment. Much of the increase in costs in health care today comes from the application of technologies. It has been documented a number of times that not all new technologies ar useful; many do not stand the test of time. In the late 1980's a study by the RAND Corporation indicated that the technologically complex carotid artery bypass operation for the prevention of strokes did not benefit a large percentage of patients on who it was performed; the operation has since been done less frequently. The even more complex "extracranial-intracranial bypass" for the same purpose, developed in the early 1980's fell into complete disuse again because of lack of documented efficacy. Today, perhaps the most controversial unproven technology is total body irradiation and bone marrow transplantation for advanced breast cancer. Its value is questionable; its cost approaches $ 200,000 per procedure. Altogether, it is estimated that as much as 30% of procedures (diagnostic and operative) performed in the care of patients may be medically unnecessary. Managed care plans by and large are more proactive in reviewing these procedures before they are performed and in indication to patients that they may not be necessary, and therefore they will not be covered.

Actually, Dr. John Wennberg of the Dartmouth University Medical School demonstrated recently that given several treatment options with roughly equivalent predicted outcomes, patients will usually choose the less complex, less risky, and almost always less costly option. Managed Care Plans, including the Lovelace Health Plan have now begun to use the Shared Decision Making Program developed by Dr. Wennberg in a further attempt to reduce unnecessary risks from complex procedures and unjustified costs.

Managed Care Pans are often accused of creating a conflict of interest in the mind of treating physicians if these physicians are either capitated for the care (same payment per patient, no matter how many services rendered) or especially if these doctors

participate in an economic reward to be paid out if the value of medical services rendered is less than a predetermined amount. But this conflict, while it is real, is no greater than the conflict the doctor experiences in recommending unjustified or marginal procedures which will yield him/her additional fees. We frequently justify the latter conflict by referring to the doctor's professionalism. The is indeed operating in the case of the majority of doctors. But why not invoke the same equally valid reason for excusing the conflict in the other direction? In fact, physicians, by virtue of the special knowledge they possess, have ability to harm their patients at every turn. It is their professional ethics that prevents them from doing so. But those ethics operate equally in each direction -- in preventing unnecessary care, and in providing all necessary care. Dr. Steven Kanig, in his testimony on behalf of the Medical Society was entirely correct in stating that managed care doctors, like doctors in general must retain a strong sense of being their patients' advocates.

The way the American health care system has evolved, various components such as the financing, the inpatient facilities, the doctors, other providers etc. have developed conflicts among themselves. Frequently these conflicts have detracted from the common goal of improved care for patients. An excellent example is the protracted battle between physicians and chiropractors; another is the relationship between many hospitals and insurance companies. Over the past several years, there has been a trend in our country toward a consolidation of various components of the system into a single vertically integrated system, providing financing, hospital care, outpatient care, physicians, therapists, other providers under one organizational umbrella, using a single patient centered documentation systems (medical records). This is a very welcome development since it reduces conflict and overhead expense while the integrated organization is prepared to assume total responsibility for the health related needs of the patient. HMOs by themselves are not integrated systems; the ones that are (Kaiser Permanente being and HMO that is fully integrated in most markets) tend to meet the needs of their customers better and have better track records in quality, service and endurance.

Albuquerque offers one completely integrated private system (Lovelace Health Systems), two partially integrated private systems (Presbyterian Healthcare Services and St.Joseph Hospital/FHP) along with two governmental integrated systems (Federal Regional Medical Center and University of New Mexico/Bernalillo County Hospitals and Clinics). Albuquerque also is a community where healthcare is a bargain; despite the general cost of living index being on the order of 101-102% of the nationwide average, The Medicare Average Area Per Capita Cost is $ 342 per month as compared to the nation-wide average of $ 376 and the average employee healthcare cost is

$ 2500 against a nationwide average of over $ 3000. A recent Milliman and Robertson study rated Albuquerque's global healthcare costs at 88 % of the nationwide urban average -- not the lowest in the country, but significantly less than the already mentioned cost of living index.

Integrated systems do not necessarily mean a single corporate entity. Lovelace Health Systems is a wholly owned subsidiary of CIGNA Healthcare Inc., which actually provides some financing mechanisms that Lovelace cannot legally provide in this State. The integration from the enrollee/patient point of view is seamless, however. There is no chance that the patient will be caught between the two corporations in a dispute. Likewise, Lovelace contracts with Diagnostek, Inc. to provide pharmacy services. They do so with demonstrated quality (with before and after customer surveys demonstrating the continuing quality) and economic advantage to the system as a whole and to the customer by keeping pharmacy payments down.

The basic principles of managed competition envision the plans offered to the public to be highly integrated. This will cause significant discomfort to those hospitals, physicians or other providers who are unable or unwilling to meet quality or other criteria of the developing integrated accountable health plans. Many of these individuals and institutions are now arguing in favor of the "any willing provider" rule that would compel managed care plans to broaden the participation of these providers, many of whose interests are actually inimical to the plan because they are not integrated with it. The "any willing provider" rule, already passed by some State Legislatures (not New Mexico) and incorporated by the Health Care Financing Administration's regulations for Medicare supplemental policies, is counterproductive to the goal of affordable high quality care.

Government Operations Committee
Subcommittee on Human Resources and Intergovernmental Relations

"Managed Care: An in-Depth Examination"
Written Testimony of
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OPTOMETRY: THE EYE CARE PROFESSION

Definition

Doctors of Optometry are independent primary health care providers who specialize in the examination, diagnosis, treatment and management of diseases and disorders of the visual system, the eye and the associated structures, as well as the diagnosis of related systemic conditions. Optometrists are health care professionals who are specifically educated, clinically trained and state licensed to examine the eyes, prescribe appropriate treatments including topical medications, and manage patients in cooperation with other health care professionals. The primary visioncare needs of consumers have shaped the scope of optometric practice as it is today.

Need For Eye Care

Over 120 million Americans are affected by vision and eye health problems. This translates to about 47 percent of New Mexico's population. Undetected vision problems can leave our youth with severe learning difficulty and contribute to failure in school. Our elderly have significant risk, as maintaining good functional vision serves to preserve their quality of life and independent lifestyle. Eye injury, eye disease and vision difficulties untreated or improperly treated can lead to permanently altered vision and inaccurate visual judgement. Poor visual judgement leads to auto, hunting and work related accidents, their resultant physical injuries, and in many cases, death. The quality of life and economic benefits of good vision and eye health are enormous. The costs of early detection and prevention are small by comparison.

Accessibility

Nationally nearly two thirds of all eye care specialists are Doctors of Optometry. Optometrists are practicing in forty-two cities and towns in New Mexico. In twenty-three of these cities no other eye care is available. This distribution affords our citizens far greater access to eye care than does Ophthalmology. By including Optometry in any health care reform package that is enacted, money can be saved for both the patient and the health care system by reducing travel costs, encouraging preventive visits and quick access to a doctor, and decreasing valuable time away from work for both employers and employees.

Cost Effectiveness

Optometric care is also cost effective. Successful HMO's and managed care networks recognize this fact by requiring that eye care patients first be seen by an optometrist. Only patients needing secondary and tertiary care are referred to an ophthalmologist for procedures such as cataract surgery or retinal detachment repair. Several research groups have documented health care savings when optometrists are utilized as primary care providers to the full extent of their training and competence: "The most cost effective models are those where optometrists perform all routine examinations and also manage certain eye diseases and conditions."

Service to Needy

Historically as a profession, Optometry has demonstrated a high participation rate in government programs serving disadvantaged communities. Optometrists have been the entry point for two thirds of low income high risk patients nationwide. In addition Optometry has been a force fighting illiteracy. Twenty seven million adult American citizens are functionally illiterate. In an attempt to combat the dramatic statistics of functional illiteracy, the Literacy Volunteers of America (LVA) was founded in 1962. As the literacy program has developed, the American Optometric Association along with the New Mexico Optometric Association recognized the need for eye care to be available to participating students. Currently in New Mexico, fifty-five optometrists in twenty-two counties provide no fee eye care (eye examinations and eye glasses if needed) to students involved in the literacy program. To date, approximately four hundred students have been provided with no fee vision care.

A second eye care program known as Vision USA (Volunteers In Service In Our Nation) provides basic health and vision care without charge to individuals without means of otherwise obtaining it. Vision USA became a national program in 1991. Nearly eight thousand members of the American Optometric Association from the fifty states (including New Mexico) and the District of Columbia donate comprehensive eye health examinations through Vision USA at no charge to those who qualify. American Optometric Association members have provided nearly 115,000 eye examinations to the needy in Vision USA's first three years as a nationwide program, with plans to continue providing eye care as long as it is needed.

High risk patients should be identified in each of the age groups listed above. Examples include premature or low birth weight infants, children failing to progress educationally, adults diagnosed with diabetes or hypertension or AIDS, any individual with a family history of glaucoma or cataracts, and all those taking medications with ocular side effects. Eye examinations should be performed more frequently for these patients, typically at 6-12 month intervals.

Acute Care

As the second component of a comprehensive benefits package, acute care should be covered for all individuals. Examples of acute care would be symptom-related, infection-related or injury-related diagnostic and treatment services. This would mean that the eye health part of an examination would be covered when the patient had a symptom, condition or complaint that necessitated the visit, similar to the services currently covered under the Medicare program.

Chronic Care

Patients diagnosed with chronic eye diseases such as diabetic retinopathy, glaucoma, macular degeneration and congenital disorders may require follow-up visits as often as every 3-6 months depending upon the severity of the condition. Costs to the health care system would be reduced by co-management of these numerous visits between an optometrist and a specialist. Similarly, optometrists are well-suited to provide pre-operative and post-operative services in many surgical cases.

Summary

Ultimately, eye care and Optometry should be included in any comprehensive benefits package that is enacted. Only by including eye care in health care reform can the visual welfare and eye health of our communities be preserved. It has been shown that for all children to progress educationally, and the elderly to function independently, preventive eye care needs to be provided. Acute and chronic care also needs to be provided as efficiently as possible in order to reduce the incidence of morbidity and even mortality for all of our citizens.

Optometry wants to be a part of the solution in reforming the health care system. Optometric care is accessible, affordable, and represents an efficient component of the health care delivery system. Including Optometry in any health care reform strategy will assure the goal of providing affordable, quality eye care to all New Mexicans.

Optometry as Primary Health Care Providers

The New Mexico Optometric Association believes that optometrists should be utilized as primary health care providers in any health care reform system. Optometry was recently listed by the U.S. Department of Health and Human Services, in their report "An Agenda for Health Professions Reform," as one of the professions that provide primary health care services, and that must be included in primary health care supply distribution reform. Many models are already in place such as the Veteran's Administration, the Public Health Service, the Armed Services, HMO's and other managed care plans in which optometrists function as the entry point into the eye care system. In addition, an eye examination is often the entry point into the health care system since many Americans with undetected systemic disease who postpone or avoid other forms of health care continue to seek eye care.

The New Mexico Optometric Association also believes that provisions for preventive, acute and chronic care services should be included in health care reform benefits. In addition, the package should continue to provide ophthalmic materials for the Medicaid population. Listed below are the eye care guidelines and services that Optometry would recommend and could provide under such reform.

Preventive Care

Newborns are typically screened at birth for congenital eye disorders and disease. In addition, all infants should receive an evaluation for vision problems and eye disease by 6 months of age. In the absence of specific problems or symptoms, a re-examination at age 3 and again at age 5 or prior to entry into school is recommended.

School age children are especially vulnerable to vision problems and vision conditions that affect their ability to learn. The youngest are often unable to tell their parents they do not see as they should or may not be aware of it. Older children are more likely to suffer rapid vision changes. Annual eye exams are recommended.

Young adults experience significant vocational and recreational visual demands. Adults in their early to mid-forties will experience changes in their ability to see clearly at close distances and suffer a slightly increased incidence of certain eye diseases. Eye examinations every 2 years are recommended.

Individuals age 65 or older have an increasing risk for the development of cataract, glaucoma, macular degeneration and other eye conditions. Annual eye exams are recommended.

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ALBUQUERQUE CENTRO FAMILIAR DE SALUD
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September 30, 1993

Congressman Steven Schiff
Congress of the United States
House of Representatives
Committee of Government Operations
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Congressman Schiff:

Please accept this as written testimony of my contribution to the organized public hearing which you conducted in Albuquerque on Sunday September 25, 1993 for the purposes of obtaining input from a variety of sources in your effort to complete an in-depth examination of Managed Care and Health Maintenance Organizations in the context of the health care reform movement.

As you know I represent the point of view that meaningful health care reform has as its core a strong emphasis on prevention and primary care. Any involvement by Health Maintenance Organizations in health care reform must be predicated on a strong commitment by such organizations to providing primary care and preventive services. Urgent care alone and health care modeled on the idea of treating illness as a focus vs. preventing such illness and providing education in this light as is now practiced by some large Health Maintenance Organizations is not an acceptable alternative.

Secondly, any reformed approach must be predicated on the premise that financial incentives should be geared toward health care which is provided appropriately commensurate with the specific medical problem. This is to say that emphasis should not be in rationing care for the sake of preserving corporate profits but the emphasis should be on providing appropriate care up front to avoid the need for costly secondary and tertiary care later.

Thus for example, it should not be appropriate for some overzealous Health Maintenance Organization to be tempted to unduly limit primary care office visits so as to preserve resources and increase profits. On the contrary, my opinion is that an effective reform principle ought to be that there should be financial incentives for those providers who emphasize prevention and primary care; not the other way around.

Thirdly, any meaningful reform ought to build on what is good and working in the present system. As you know, I have been a strong advocate for primary care specifically as it is embodied in the Community Health Center concept. The whole purpose of the Community Health Center is to provide primary preventive care to persons and groups who might not otherwise have access to health care through the traditional means for a variety of reasons.

Many of these centers have existed for over 25 years developing an infrastructure in terms of both facilities and staff and the building of a considerable patient following. It is estimated for example that there are over 70 million patients who regularly receive their primary care at these centers. In your jurisdiction there are over 30,000 patients who are provided care by these centers.

Because of the federal support through Section 330 of the Public Health Service Act, these Centers have been able to thrive. However because of the flat funding they have received over the years, many of them have not been able to keep their facilities and infrastructure updated. These centers are not able to financially compete with the existing, well financed Health Maintenance Organization.

If Managed Care and HMO's are to be the centerpieces of the new reform movement, it is essential that Community Health Centers be recognized and supported so that they may continue to provide services to vulnerable populations who may have cultural, linguistic, geographic and other access problems which are not taken into account by the corporate culture of the commercial Health Maintenance Organization stakeholder.

Health Maintenance Organizations must be required to deal fairhandedly with Community Health Centers in terms of subcontracting arrangements for the provision of primary care. Community Health Centers do not have the experience of having a healthy market share from which to build their financial systems. They have had to do an almost impossible job with meager resources. It may be argued that it is because of this lack of incremental support that the centers have not made an even more dramatic impact at making primary care services accessible to vulnerable uninsured populations.

To eliminate the Community Health Center as we know it from the playing field of Health Care Reform over the long term as is being proposed under the President's plan is toying dangerously with the systems which have made so much progress in their work with vulnerable populations such as ethnic minorities, women and children, migrant and seasonal farm workers, the homeless etc.

I have had the honor of Chairing a Policy Information Working Group, a part of the New Mexico Legislative Task Forces Advisory Committee on Health Care Reform. I think you should know that Preventive care, and the creation and support of a Community Based delivery system were among the top priorities which will be recommended to the Legislative Task Force by the Advisory Committee. There appears to be strong support not only for a delivery system which emphasizes prevention and primary care; but also one which emphasizes a delivery system which is based on the community and its needs.

I submit that these two principles are the cornerstones of the Community Health Center System. I urge your continued support for this system. I also strongly encourage you to work toward ensuring that if HMO's and Managed Care are going to be the cornerstones of health care reform, they should be held to supporting and working cooperatively with Community Health Centers as we move forward in the rebuilding process of our national and state based health care system..

Thank you very much for allowing me to provide you with my observations. You are to be commended for your effort to gain input from your constituents in the all important matter of health care reform.

Sincerely,

E.E. "Tex" Ritterbush, President
Albuquerque Family Health Center, Inc.

The New Mexico Psychological Association

PROPOSED GUIDELINES
FOR THE DELIVERY OF MENTAL HEALTH SERVICES
WITHIN MANAGED CARE ORGANIZATIONS

The New Mexico Psychological Association members have provided effective mental health services within managed care organizations for almost 20 years. This experience allows us the persepctive to develop a number of proposals aimed at improving the quality of care while at the same time improving the efficiency of the overall health care system.

These proposals involve the following issues:

I. QUALITY OF CARE:

*Mandated Mental Health Care for all Citizens of New Mexico.
- Approximately 22.5% of the adult population have a mental disorder during their lives. However, almost 25% of the state's population is uninsured and lacks access to the mental health care system.
- New Mexico's suicide rates and substance abuse problems are among the higheat in the nation.

*Integrate mental health care within the overall health care system.
- As many as 60% of visits to primary care physicians are mental health related. Appropriate referral to mental health professionals reducea the overall cost of health care while improving overall quality of care.

*Emphasize prevention, early detection and outpatient care.
- 70-80% of mental health dollars are currently spent on inpatient care. Dramatic savings can be obtained by increasing benefits for outpatient care.

*Increase accessibility of providers and consumer choice by expanding provider panels.

II. CONSUMER PROTECTION:

*Improve confidentiality of records, now comprised by loose utilization review procedures.

*Demand financial disclosure of any financial incentives to limit treatment.

*Improve appeal and grievance procedures regarding treatment decisions.

III. STREAMLINE THE SYSTEM:

*Improve utilization review procedures by using licensed practioner reviewers who can communicate effectively with providers.

Publish review criteria and do not allow the time lag for review to interrupt continuity of care.

*Standardize forms across the industry.

PROPOSED GUIDELINES FOR THE DELIVERY OF MENTAL HEALTH SERVICES WITHIN MANAGED CARE ORGANIZATIONS

I. OVERVIEW. The New Mexico Psychological Association recognizes that Managed Care Organizations play a significant role in the delivery of mental health services to the people of New Mexico. For over twenty years, research findings have indicated that well-integrated mental health services within a well-run managed care health delivery system produce effective results for the consumer. NMPA has developed a number of proposals aimed at improving the delivery of services while at the same time improving the efficiency and quality of services delivered:

II. QUALITY OF CARE ISSUES:

A. Mandated Mental Health Benefits. Numerous research studies indicate that there is a dramatic decrease in general health care costs when accessible mental health services are included in health plans.

* As many 60% of visits to primary care physicians are actually mental health related. The experience of the Kaiser-Permanente Plan for example, is that appropriate referral of these patients to mental health providers results in increased quality of care, increased efficiency of the medical delivery system and an overall reduction of costs.

* Treatment successes for major mental disorders are now 60-90% (By comparison, the success rate for angioplasty as a cardiovascular treatment is 41%).

* 85% of mental health consumers make fewer than 15 visits.

B. Emphasis on Prevention, Early Detection and Outpatient Services. Many managed care programs currently have relatively liberal hospitalization benefits and limited outpatient benefits. This is backwards:

* 70-80% of mental health dollars are currently spent on inpatient services, primarily for substance abuse and adolescent hospitalization. Numerous research studies illustrate that dramatic savings can be obtained by emphasizing benefits for prevention programs, aggressive outpatient treatment, and continuum of care programs such as half way houses, group homes and partial hospitalization programs.

C. Accessibility of Providers and Consumer Choice. Currently many managed care systems have very limited panels of providers, resulting in some cases in waiting lists for care.

*Consumer preference polls and research studies indicate that care is improved when the consumer has access to a larger number of providers and the ability to choose providers.

III. CONSUMER PROTECTION.

A. Confidentiality. Confidentiality should be strictly enforced in a manner consistent with professional ethics guidelines and legal requirements. Managed Care Organizations should be required to disclose confidentiality procedures, and limitations to the consumer. Currently, this protection is lacking within many systems.

B. Financial Disclosure. Information regarding financial arrangments should be disclosed to the consumer. This includes incentive plans that link a provider's treatment decisions to income which the provider will receive from the plan.

C. Right to Appeal Decisions. The consumer should have the right to appeal decisions, including access to a mediator through the state insurance commission. Appeal proceedures should be clearly stated to the consumer and the provider.

* Currently most Managed Care Organizations have "No Cause Termination" clauses in their provider contracts which have the potential be used to discipline or terminate providers who submit too many appeals or grievances on behalf of the consumer.

* Eliminate the practice having providers sign agreements which waive the managed care organization's liability for negligence/malfeasance in cases that arise from utilization review decisions. This a major factor in producing mistrust and poor relationships between the provider and the organization, and ultimately leads to consumer mistrust.

IV. STREAMLINING THE SYSTEM. Inefficiency within the system can be greatly reduced by:

A. Improved Utilization Review:

- Improve communication by using reviewers who are licensed practioners and belong to the same professional discipline as those providers under review. This will greatly reduce appeals which are the result of the reviewer not understanding the basis for treatment requests.

- Publish the criteria for review decisions and disclose them to the consumer and the provider. Many Managed Care Organizations currently do not do this.

- Do not allow the utilization review to interrupt the continuity of care. The current time lag between request for treatment approval and the actual approval interrupts the care, causing increased problems for the consumer who needs timely care.

B. Standardize Paperwork. Develop standardized record forms, utilization review procedures, claim forms and credentialling forms across the industry.

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THE COMMITTEE ON GOVERNMENT OPERATIONS
SUBCOMMITTEE ON HUMAN RESOURCES AND INTERGOVERNMENTAL RELATIONS
CONGRESS OF THE UNITED STATES

REGARDING

MANAGED CARE: AN IN-DEPTH LOOK AT HMO'S

TESTIMONY BY:

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5 October 1993

INTRODUCTION

As a third year medical student at the University of New Mexico School of Medicine (UNMSM), I hope to offer to the House Committee On Government Operations a useful viewpoint on Managed Care and its role in the upcoming Health Care Legislation. I have been very active in the American Medical Student Association (AMSA), serving as the UNMSM's AMSA Chapter President and as National Co-Coordinator for AMSA's task force on Death and Dying. Last summer, I presented my research findings on physician and patient knowledge and Attitudes about HIV at the International AIDS Conference in Berlin, Germany.

COSTS OF THE CURRENT PROPOSED FORMAT

I strongly urge the committee to critically review the cost projections for the proposed plan. Having a health care plan administered through corporations and regional health care alliances adds a layer of costly bureaucracy compared to the cost of a single payer plan. Administrative costs must be kept to a minimum if we are to receive the most services for our health care dollar.

PATIENT-TO-PHYSICIAN RATIO IN HMO's

The number of patients typically handled by each physician in an HMO is currently very high. While an attractive from a cost per patient standpoint, this high ratio seriously erodes the quality of the physician patient relationship. This is particularly important when, as conscientious health care providers, we attempt to encourage behavior that promotes health. Smokers, for example, are much more likely to quit when a physician with whom, over several visits, they have developed a close repoire, encourages them to quit. This is because the physician can "stay with" the patient through the several lapses that normally occur, until the patient does, in fact, stop permanently. The current HMO system, requiring a large patient load, make it very difficult to develop such solid, ongoing relationships.

STANDARD OF CARE OFFERED BY HMO's

My conversations with medical residents and physicians show clear criticism about the standard of care HMO's offer. In one such conversation, an Internal Medicine Resident described great frustration at her HMO experience because of the difficulty of "justifying" and obtaining lab tests except when patients are in crises. She suggested that a patient would have to suffer the complications and draining fatigue of a weak thyroid gland for as much as six months before the appropriate test (for levels of Thyroid Stimulating Hormone) would be approved. She also described the notorious case when the UNM Cancer Center had to obtain a court order to force an HMO in our area to provide cancer treatment for a patient, a treatment routinely available to patients carrying private insurance. The unhappy, ironic ending was that though the court ultimately ruled in the patient's favor, the litigation dragged so long that, by the time of the ruling, the cancer

had progressed beyond the point where the treatment could help. The patient died shortly after he "won" in court.

In another conversation, I spoke to a psychiatrist who opted out of joining an HMO. She believed the care provided by all HMO's in our area was substandard, noting that it was her perception that HMO psychiatrists in our area are not well respected within our psychiatric community. The HMO psychiatrists have too little time to spend with their patients. In any case, HMO cost control measures often left too few resources to allow appropriate care. She offered one of her patients as an example: a sixteen year old woman who suffered a psychotic break. The patient's parents were enrolled in an HMO, which nominally covered their daughter (the patient) as well, yet they were also forced to utilize psychiatrists outside the HMO. When the psychotic break occurred, the HMO psychiatrists refused to admit her. The young woman then escaped from her family's home and wandered the streets of Albuquerque for several nights until she was found. Only then, after this agonizing and potentially dangerous trial, did the parents return to the HMO and aggressively insist that their daughter be admitted for in-patient care, at which time she was finally admitted. The cost incentives inherent in HMO operations make mistakes of this kind almost inevitable.

HMO's SERVING POPULATIONS THAT PREVIOUSLY HAVE NOT BEEN TREATED

I am, myself, currently enrolled in an HMO through my husband's company's health care coverage. My care to date has been adequate... but I am a highly functioning individual who is both articulate and very familiar with the current culture of our medical system, as well as the ins and outs of their bureaucracies. The advantages that I can obtain from almost any health care system, including those modeled on HMO's, are quite different from those less fortunate in our society.

To illustrate this point, I draw upon my own experience. A few years ago I assisted a friend in medical school with a research project that assessed the prevalence of HIV infection and HIV risk factors in our population of prostitutes in Albuquerque. For roughly a month and a half, I assisted in drawing blood and questioning this population. This study found that less than 3% of our sample was infected with HIV. We offered a variety of health services to this population if they came into a public health clinic... but no one came in. We had to hit the streets again, and find our study subjects. Only by this effort could we counsel them on their HIV status, and offer them protective strategies.

Many of our study subjects were addicted to heroin and were illiterate. Their life style was vastly different from that which our medical culture was familiar with. Yet these people were mothers and fathers of children and were people whose interactions affected those around them. They all wanted to remain free of HIV. Yet, unfortunately, our current health care system could not supply them with adequate resources and knowledge to keep them free of HIV. Outreach was required... my friend was able to develop a health education strategy that fit their needs. It was more expensive than sitting back and waiting for patients to come in, but far less expensive than treating the extra HIV cases that would probably result from the traditional approach. Fortunately we had the

flexibility and resources of our university to develop and implement this kind of approach, but you will rarely, if ever, find this kind of flexibility in an HMO environment.

This enlightening experience led me to begin to wonder how many sub-populations there were whose health care needs were not being met by our current system. One such group is the adolescent population in our public schools. They typically receive little health care and almost no preventive medicine education. Many of these children are members of families who do not have health insurance. In order to provide them with basic health care, UNMSM has opened a number of school-based clinics in disadvantaged areas. Health care provided at these clinics is oriented toward the psychology of an adolescent and offers preventive health care as well.

PREVENTIVE MEDICINE AND HMO's

In attending the International Aids Conference in Berlin, Germany, I witnessed the frustration of the medical community spending millions of dollars in trying to develop a vaccine for HIV. The research community, stymied at solving a technical question, has turned to the question of how to modify behavior in order to prevent the spread of HIV. Just as the AIDS Health Care Community is realizing that it may be more effective to spend less money on cures for AIDS and more money on prevention, we as a country can save money with our health care dollars by focusing on prevention as well as a cure.

CONCLUSION

I have learned that health care can be provided in a manner that is not necessarily costly, but that is sensitive to the culture of the patient, and that both good health care and prevention of future health problems is thereby possible for all patient populations.

Since much of the HMO activity is focused on curing patients who "walk in" with problems to be solved, they do not have the organization, incentives, or experience to treat out-of-mainstream populations, particularly with the low cost preventative care that can be so effective for these groups. I am therefore not convinced that the HMO model, adopted alone, provides an adequate basis for national health care.

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